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ABSTRACT

This issue presents five articles on the theme of professional development of personnel serving infants and toddlers. The papers describe: experiences in the Training of Trainers Intensive Seminar and the City Training of Teams initiatives, an Illinois developmental training and support program, a Canadian 12-month training program, the use of first person narratives in professional and parent development, and the ethics of requiring self revelation in professional development programs. Papers have the following titles and authors: (1) "From Use of Skills to Use of Self: Professional Development through Training To Enhance Relationships" (Barbara Moss and Barbara Wightman); (2) "The Ounce of Prevention Fund's Developmental Training and Support Program: Building Relationships To Promote Positive Developmental Outcomes" (Candice Percansky and Nick Wechsler); (3) "Linking Knowledge and Experience: A Model for Training Infant/Toddler Caregivers and Infant Mental Health Practitioners" (Nadia Hall); (4) "Personal Narratives and the Process of Educating for the Healing Partnership" (Elaine H. Walizer and Patricia Taner Leff); and (5) "Of Elephants, Ethics, and Relationships: Tools for Transformation in the Training of Early Intervention Service Providers" (Carole Brown et al.). In addition to the five papers, the publication includes news items such as training institute announcements, notes, new publications, letters to the editor, new videotapes, and conference calls. (DB)

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[Professional Development and Training for Early Intervention Service Providers]

Emily Fenichel
Editor

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National Center for Clinical Infant Programs

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From Use of Skills to Use of Self: Professional Development through Training To Enhance Relationships

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The world of work with infants, toddlers and their families involves relationships—relationships with parents, with children, with colleagues, and with the larger professional community. But the training of early intervention providers seldom includes explicit attention to an understanding of the power of relationships. Most preservice professional training is not designed to help practitioners learn to establish, maintain, and strengthen relationships that are collaborative, respectful and rewarding to all participants. Instead, current training practices all too often perpetuate models of relationships characterized by dependency and an inequality of power. Relationship is devalued altogether—the fully competent individual practitioner is presented as the professional ideal.

As early intervention professionals trained in the early 1970s, we have had the experience of achieving reasonable competence in the "skills" of independent therapeutic intervention with young children, only to discover that the **real** world of work involved a host of complex relationships, with which we were, as beginning practitioners, ill-prepared to cope. Only recently have we learned to move from the exercise of specific skills to the professional use of our entire selves. We have exchanged the dream of being the solo practitioner who knows everything for the hope of becoming a member of an interdependent professional community, in which expertise is pooled and shared. Part of this process has involved, for each of us, participation in intensive, innovative training initiatives sponsored by **ZERO TO THREE**/National Center for Clinical Infant Programs—the 1990-91 Training of

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Trainers Intensive Seminar (TOTIS) and the 1992-93 City TOTS (Training of Teams) project (see box, page 3).

In the pages that follow, each of us describes something of her own journey from use of skills to use of self. We hope that some readers will recognize roads that they, too, have travelled. We hope that other readers will find our experience helpful in guiding their professional paths and in supporting the students who look to them for leadership.

Integrating the perspectives of two disciplines: Barbara Moss

I was trained initially in speech pathology and audiology, learning to work in a rehabilitative mode with children and adults with communications disorders. Later I received training in psychotherapeutic concepts and techniques for working with individuals and groups. Since I learned psychotherapeutic concepts outside a formal university training program, I found that I had less confidence in my knowledge and skills in this area. Until quite recently, I was more comfortable in practicing my rehabilitative skills – rehabilitation still seems like my "real" job.

In the early part of my career, training involved acquiring skills – learning how to "remediate deficits" in the clients who came to me. Once I had successfully completed the requirements for certification as a speech/language pathologist, no real professional supervision was offered to me. Nor did I seek any.

However, largely because my family is full of social workers, I began to attend training seminars in group psychotherapy. (I must confess that I began attending these seminars because of the entertainment afforded by their experiential component, but I soon became "hooked" on group psychotherapy.) When an opportunity for more training became available in Dallas, where I lived, I took advantage of it and completed a two-year program. This included weekend didactic and experiential sessions designed to acquaint participants with different theories and techniques of psychotherapy – psychoanalysis, Gestalt theory, Transactional Analysis, etc. During this time, I sought group therapy for myself and participated in a group for about 14 months.

Following completion of the training, I apprenticed myself (on a very part-time basis, since I held a full-time job as director of speech and hearing services for Dallas County Mental Health/Mental Retardation) to two therapists. Under supervision, I provided both group and individual psychotherapy. This was my only experience of clinical supervision.

While I did learn techniques of psychotherapy, I now realize that I did not make the connection between personal insights gained in my personal therapy or clinical supervision with the implementation of psychotherapy or my work with the communicatively impaired.

The things I learned in my personal psychotherapy and in clinical supervision were about myself and how I

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ZERO TO THREE's TOTIS (Training of Trainers Intensive Seminar) and City TOTS (Training of Teams) Initiatives

ZERO TO THREE has identified four elements of training that seem particularly likely to help individuals become competent infant/family practitioners. These are:

- A knowledge base built on a framework of concepts common to all disciplines concerned with infants, toddlers, and their families;

- Opportunities for direct observation and interaction with a variety of children under three and their families;

- Supervision and mentoring relationships that allow the trainee or practitioner to reflect upon all aspects of work with young children, families, and colleagues from a range of disciplines; and

- Collegial support, both within and across disciplines, that begins early in training and continues throughout the practitioner's professional life.

ZERO TO THREE's Training of Trainers Intensive Seminar (TOTIS) and the City TOTS (Training of Teams) project (funded by the Prudential Foundation's Focus on Children) have incorporated the four elements of training in a model designed to help trainers improve the training and professional development opportunities that are available to infant/family practitioners in their own agencies, communities, or states. In the 1990-91 TOTIS project and the 1992-93 City TOTS program, participants have come as teams to an intensive one-week residential seminar, followed by a nine-month period during which teams have planned and implemented projects they have designed and refined to meet specific training needs of their agencies, home communities, or state professional development systems.

As the accompanying article notes, TOTIS and City TOTS seminar weeks featured discussions of key concepts that have emerged as powerful integrators of information across fields of inquiry and as general guides for practice that are useful to many disciplines. Individual differences, parenthood as a developmental process, the helping relationship, and transactions between the infant and the environment are the concepts emphasized during TOTIS and City TOTS seminar weeks. Supervision and mentorship, another key element of training, have been illustrated through role play and described as they occur in various disciplines and infant/family work settings. TOTIS and City TOTS have also offered visions of supervision and mentorship as relationships for learning, characterized by reflection, collaboration, and regularity.

TOTIS and City TOTS participants are encouraged to view development in the earliest years and their own work as infant/family professionals through the lens of relationships -- relationships between infant and caregiver, student and teacher, parent and professional, and worker and colleague. As Jeree Pawl, a faculty member at both TOTIS and City TOTS has noted, "While recognizing the many internal and external influences on a child's development, we must focus particular attention on the quality of infants' and toddlers' major relationships and on children's day-to-day experiences within these relationships. From the first moments of life, it is these relationships and these experiences that shape children's sense of self, the world, and their place in it."

Seminar week faculty have represented a range of disciplines and backgrounds. **ZERO TO THREE** staff members Linda Eggbeer and Emily Fenichel have co-directed TOTIS and City TOTS, providing consultation and technical assistance to teams from the application process through the follow-up period. They also link individual participants and teams to other professional development opportunities offered by **ZERO TO THREE**. Five Resource Consultants have linked the TOTIS and City TOTS initiatives. Since they participated as team members in TOTIS, the Resource Consultants were able to provide a "consumer's" perspective during the planning of City TOTS a year later. During the City TOTS seminar week, Resource Consultants linked faculty, teams, and individual participants by facilitating small group sessions, offering technical assistance to teams, and bringing to faculty deliberations an empathic understanding of what City TOTS participants were experiencing.

*For more information about **ZERO TO THREE** training initiatives, contact Linda Eggbeer or Emily Fenichel at **ZERO TO THREE**, 2000 14th Street North, Suite 380, Arlington, Virginia 22201.*

operate, think, and feel. Although the changes that resulted from my personal psychotherapy were bound to have an effect on my work, I didn't consciously recognize those insights as having much to do with my professional life. I had not yet learned that the conscious use of self was related to working with people.

Nothing in my speech pathology training taught me to pay attention to what was going on inside me. We were told that it was useful to "establish rapport," but no one said what "rapport" was. I learned that a good relationship with the client was an essential precondition for therapy. I did not yet understand that the relationship was an essential part of treatment. My concern was still to "find a technique that works with a particular client," whether psychologically or communicatively impaired. I still kept the insights from my personal therapy separate from my work. In fact, I had separate collegial support groups – one of speech therapists and another of psychotherapists. I didn't know anyone who did both kinds of therapy and thought I had a unique situation.

I learned that a good relationship with the client was an essential precondition for speech therapy. I did not yet understand that the relationship was an essential part of the treatment.

This difficulty in integrating the two sides of my training continued even after I started working in Texas' Early Childhood Intervention (ECI) program, ten years ago. I realized quickly that child development knowledge and child-oriented therapeutic skills were not enough. Additional skills were necessary to work with the child's family. Most of the staff I hired for my ECI program had the skills necessary to work directly with a child with a developmental delay but very limited experience in working with families. Social workers were the exception: they were comfortable working with families, but not comfortable working with the child. Our initial response to this situation was to assign some staff to work only with the family and other staff to work only with the child.

The TOTIS experience

In the summer of 1990, I was a member of a multidisciplinary team of professionals from Dallas who participated in ZERO TO THREE's Training of Trainers Intensive Seminar (TOTIS). During the week-long residential seminar, I felt a merging of my separate training in communications disorders and psychotherapy. I could see how to integrate my "closet" psychotherapy training into work with families with young children who were developmentally delayed. I was uncomfortable, however, because I wasn't sure that it was proper and legitimate for developmental therapists to be concerned about their internal processes and those of their clients. I was worried about issues of skill: Speech pathologists had not been trained in "mental health"; perhaps they would do more harm than good "messing" with people's psyches.

Clinical supervision models that I knew about and those modeled at TOTIS seemed to require mental health training. Feeling pretty shaky about my own grasp of mental health concepts, I didn't think other developmental therapists would be able to use newly acquired supervision skills in a helpful way. Indeed, one participant in a workshop on supervision sponsored by the Dallas TOTIS team expressed the fear that "things could get opened up in clinical supervision" and no one with "real" training would "be there to fix it." Some participants expressed concern that a clinical supervisor lacking mental health training could do psychological damage. Others remained unclear about the distinction between supervision and therapy. Some early intervention practitioners were adamant that "that therapy stuff" had no place in supervision in an early intervention program.

Nevertheless, after TOTIS I felt ready myself to apply what I had learned about reflective supervision and the nature of the helping relationship to my own work. Since I had already been "cross-trained" in group psychotherapy, the TOTIS experience validated the skills and knowledge I had gained from that training. I now felt "legitimate" in applying these skills to work with families and their young children. Moreover, I found other early intervention providers who were interested in what I was doing. We formed a peer supervision group and quickly discovered it to be a very valuable support. We found and became involved with individual mental health professionals who were interested in infants and toddlers, and with the Texas Association for Infant Mental Health. I surrounded myself with readers of Selma Fraiberg's "Ghosts in the Nursery' and devotees of *Zero to Three*.

Because peer supervision was so good for me, I arranged clinical supervision for my 15-member clinical ECI staff. Currently all my staff, trained in speech pathology, nursing, occupational therapy, social work, education, psychology, and counseling attend a clinical supervision group twice a month. Although reluctant at first, staff quickly saw the relevance and applicability of supervision to their work.

City TOTS

Early in 1992, all TOTIS participants received letters from ZERO TO THREE/National Center for Clinical Infant Programs announcing the funding of City TOTS and inviting them to apply to be Resource Consultants in this new initiative. Our job would be to use what we had learned through the TOTIS experience to help both faculty and teams. I applied and was selected, as were Barbara Wightman, Annette Axtmann, Trudi Latzko,

and Arlene Restaino-Kelly.

We Resource Consultants used our recollections of the high points and shortcomings of the 1990 TOTIS seminar week to help faculty and staff plan the 1992 City TOTS seminar week. During the week, we facilitated a variety of small groups and helped individuals and participating teams as they worked to process substantive material, began to plan their follow-up projects, and struggled with relationships within and beyond the team.

I used the three-day City TOTS planning meeting and subsequent staff/faculty/Resource Consultant communication by mail and phone to strengthen my own knowledge and understanding of the conceptual framework that formed the basis for both TOTIS and City TOTS (see page 3). I realized how important a conceptual framework is for me in allowing me to integrate the things I learn. After spending three days discussing how to teach this conceptual framework, I understood it much better than I had before. (This no doubt has something to do with the fact that Resource Consultants, faculty, and **ZERO TO THREE** staff were trying hard to clarify areas that had remained murky in the original 1990 seminar week. It may also have something to do with the old adage that the best way of learning something is trying to teach it.)

During the City TOTS seminar week, which brought together 50 participants (in 10 teams, from nine cities), seven faculty members, five Resource Consultants, and two **ZERO TO THREE** staff, I experienced the importance of relationships in a new way. I became freshly aware of the meaning of "the conscious use of self" in a relationship, and that the relationship in which learning occurs can be more important than the content of what is being taught. I became more aware of reciprocity – between trainer and trainee, and between client and therapist.

During City TOTS seminar week, I became more aware of reciprocity – between trainer and trainee, and between client and therapist.

Cognitively, I had known for a long time that training is not just skills exchange from "teacher" to "student," that training is a two-way street. But during the City TOTS seminar week, I **experienced** that knowledge in a transforming way. I could see implications – for me in working with my staff of supervisors; for my supervisors as they work with caseworkers, speech pathologists, occupational therapists, and other professionals; and for all of these practitioners as they work with families.

Currently, I have the opportunity to offer clinical supervision to other providers of early intervention services. For two years, a local consortium organized to distribute funds available through the Texas Children's Mental Health Plan (a collaborative effort by statewide agencies and human service coalitions working with children and families) has funded three clinical supervision workshops, along with other projects. The consortium, whose goal is to increase services for infants and toddlers prenatally exposed to drugs and alcohol, just concluded planning for the second biennium of funding. Clinical supervision was everyone's top priority for re-funding. Not only will the three previously funded groups continue, but we will add a fourth clinical supervision group in fiscal years 1994 and 1995.

Interestingly, it was staff from protective services, early intervention, and drug treatment programs – who had initially been suspicious of clinical supervision – who demanded that the groups continue. During six months of experience with clinical supervision, these practitioners moved from reluctance to unabashed enthusiasm. When they realized that supervision groups were not going to focus on their personality "deficits," practitioners found the groups supportive. Through reflection, they could see parallels between what was happening in the groups and what was occurring for them in their daily work. They gained insights that translated into more rewarding relationships with colleagues and with clients.

Training for participation in a professional community: Barbara Wightman

Early intervention legislation and other major publicly and privately funded early childhood initiatives are becoming a significant stimulus for systems change in the delivery of services for young children. New approaches to supporting the development of infants and toddlers emphasize family-centered parent/professional partnerships and interdisciplinary practice, through community-based services. In recognition of the need for well-trained practitioners, increasing attention is being focused on strategies of training early intervention personnel, both at the pre-service and in-service level.

I believe that to transform services, we must find training methods that transform individuals. We must recognize that the real world of work involves relationships, and we must prepare students and current service providers to have effective relationships, by teaching them how to become partners with families and participants in a multidisciplinary professional community. Training experiences should equip students and current service providers with ideas and perspectives that will influence, guide, and challenge them throughout their professional careers, even when their job responsibilities and work environments change.

Unfortunately, many traditional training practices at both the pre-service and in-service level are more likely to undermine students' and practitioners' collaborative skills than to support them. The intent of pre-service training is to provide a firm foundation in a particular set of skills, failing to recognize the students' internal processes or the importance of the helping relationship as an integral component of any therapeutic effort. Such

training practices limit professionals' effectiveness as therapists and isolate practitioners from intellectually enriching and emotionally supportive relationships with colleagues.

Dependency, inequality and the deficit model

Traditional approaches to training, especially in medicine and allied health professions, focus on "fixing" a specific problem or deficit. The problem is located in a specific body part or domain of functioning within the "patient." Competence to heal illness or restore functioning is what the student must acquire, through training in the skills of his or her chosen profession. In this model, the problem is seen as part of the patient, but the patient is not seen in relation to his family, his community, or even his own individual problem-solving resources. The burden of fixing the problem is laid solely on the practitioner/helper.

Such an approach creates a relationship of dependency and inequality of power between the practitioner, who (theoretically) knows everything, and the patient, who knows nothing. For the new practitioner, identifying oneself as the expert or authority in a specialized area can be a heady experience. Some professionals, indeed, remain impressed with their perceived level of expertise. For them, any failure to solve "the problem" must reside in the patient, "who did not comply with the recommended treatment." Other professionals blame themselves for lack of skill, "burn out," and leave the field. Still others engage in searches for "the magical missing skill" which will restore their feelings of competency.

Political and social messages about competition and "rugged individualism" do not reinforce indentification with a community – even a professional community.

Deficit-model training says nothing about reciprocity and offers the student no shared experiences of resolving problems collaboratively with a patient. The training of medical and allied health personnel sometimes becomes almost a caricature of traditional training of physicians, with prescriptive "order-giving" and emphasis on "clinical distance" as the model.

We are not taught how to relate; in fact, we are taught not to relate. Consider the traditional scenario for informing parents of their child's diagnosis. The room may contain several professionals, with one delegated to deliver "the news." The setting is not intimate; the process is not gentle. Touching the parent is unacceptable. And if a parent cries, you offer a kleenex, while everyone waits uncomfortably for "the moment" to end. This is "clinical distance," and we are taught to "maintain" it.

Knowledge, it is said, is power; but knowledge kept to oneself, uninformed by feeling, protected from questions and challenges can lead to abuse of power. If a therapist tells a parent, however mildly, "Never put your child in a walker!," this is the end of the dialogue. The parent may follow the therapist's recommendations to the letter (perhaps to the detriment of the parent's own need for brief respite), or the parent may "defy" the therapist. But in either case, opportunities for relationship and joint problem solving around the family's reality are missed.

Barriers to a sense of professional community

To understand barriers that prevent practitioners from developing effective relationships with their professional peers, we must look at political and societal messages that influence the way professionals interact with one another.

Our society values both competition and "rugged individualism." The political and societal messages that transmit these values do not reinforce identification with a community – even a professional community. These messages, moreover, place the practitioner in a very precarious position. Competition is designed to produce a single "winner." The competitive professional, striving to demonstrate individual competence, is isolated from her professional environment. We absorb the message that we must never reveal inadequacies, vulnerabilities, or weaknesses. We must never acknowledge that the skills we have been taught may not "fix the problem."

Supervision in many early intervention professions and settings is reduced to an annual agency performance evaluation ("She dresses appropriately and has good work habits"). We are trained neither to seek support, through regular, reflective supervision or mentorship, nor to value interdependence among practitioners in the field.

Under the guise of "consultation," we may pretend to seek out our professional community. But in reality, we tend to look for a second opinion from a professional who will mirror our own beliefs. Seldom do we use the process of seeking a second opinion as an opportunity to look for collective, collaborative, innovative solutions to challenging problems.

Established patterns of competition, individualism, and isolation may make "teaming" a charade. Students may learn the multidisciplinary, interdisciplinary, transdisciplinary, group process, and team interaction jargon, but seldom are trained in the skills of conflict resolution, as a way for team members to relate to one another when disagreements arise. At least one study (Sands, Stafford, and McClelland, 1990) has shown that the ultimate decision maker on any given treatment team is usually the individual who has the highest degree and makes the most money (typically the physician or psychologist). Some lessons are being well-learned.

Another barrier to participation in a professional community is the tendency for practitioners to identify

with the precepts of their professions or their work settings while discounting their individual, subjective, lived experience. Practitioners tend not only to maintain stereotypical expectations of members of other professions; they may even maintain cliques within their field that further reduce opportunities for sharing different perspectives and experience.

Although early interventionists give lip service to the importance of individual differences among children, we rarely acknowledge, much less build on or celebrate, the individual differences that exist among all professionals, even those in the same field of work. This denial of our individual self-knowledge is a denial of the rich cultural complexity of our community heritage, which moves beyond our narrowly constructed professional identity.

TOTIS and City TOTS: Isolation busters and community builders

Barbara Moss has described above the ways in which **ZERO TO THREE**/National Center for Clinical Infant Programs' TOTIS and City TOTS training initiatives have been designed to help trainers in the infant/family field integrate the perspectives of a range of professional disciplines, cultures, and experiences of parenting, by looking at both early development and service delivery through the "lens of relationship". As a participant in TOTIS 1990, I found that focusing this lens on my own professional training and its subsequent impact on my practice revealed what an isolating experience it had been. This shift in focus was/is very subtle, continues to evolve, and is not easy to put into words.

Before participating in TOTIS, I had considered myself as very committed to my profession, always eager to learn, always ready to become more proficient. I thought of myself as completely dedicated to the best interest of the child/patient and the child's family. But as I adjusted my "lens," I saw that my dedication had been to my own agenda. This agenda was a product of my solid professional training, and it was often at the sacrifice of my relationships to families, their children, and other practitioners.

My perception of my "expertise" and my pervasive (if unconscious) feelings of ownership were part of the picture. At this time in my career, I viewed myself as the "local expert" in pediatric occupational therapy. Maintaining this "official" position was very important to me. To be considered knowledgeable and impress other "expert" professionals, I found myself frequently describing my years of experience, the renowned institutions where I had trained, and the "big names" with whom I had studied. My feelings of ownership, I came to realize, were obvious every time I talked about "my" program, "my" agency, "my" staff, "my" families, "my" children, and "my" success.

As I began to question this view of my professional world, I began to experience a professional crisis. I could

Barbara Young

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not separate commitment from ownership. How can one be committed to something without being invested in it? How can one be committed to something without claiming it as all one's own? Although others thought that I was very good at my work, I became ambivalent about it. I reflected on the countless reports I had written about children and realized that the reports would definitely impress the experts, the professionals who had trained me. But the technically worded reports were incomprehensible to the families I was supposed to be serving. I began to ask myself, "Who and what am I doing this for?"

I was in conflict. If my treatment recommendations, based on sound knowledge, were correct, then how could I "back down" and fail to give these recommendations priority over the family's needs or the recommendations of other professionals? I could not continue to work as I had been trained to work, but I could see no other way of working. I began to withdraw; I began to think a lot about introspection, caution, and humility.

When the concept of supervision and mentoring was introduced at TOTIS, I was outraged at the suggestion that supervision could occur after every visit with a family. Anyone who needed that much supervision surely could not be competent to practice! My own previous experience of supervision – an annual performance evaluation – had not prepared me for the notion that supervision could be an opportunity for support and professional development.

To be perfectly honest, I was annoyed with the whole TOTIS seminar.

To be perfectly honest, I was annoyed with the whole TOTIS seminar. I had expected that something called a Training of Trainers Intensive Seminar would give me clear-cut training objectives (just like the numerous other training sessions I had attended). I expected carefully directed skill development, which would progress sequentially to a predetermined outcome. I did not expect to find trainers/professionals struggling willingly and honestly confronting the complex questions of our field. These trainers did not offer concrete "answers." Instead they explored and offered up a dialogue, wrestling with situations in which there are no clear answers. Training as an experience? An exploration without a predetermined official, expert judgment? I didn't get it ....until much later.

Following the 1990 TOTIS, I began to experience real change. I had an opportunity to work with children, their families, and a team of professionals again. The relationships began to feel different. There was more uncertainty, but there was also a new openness and vulnerability within myself that was refreshing.

When the City TOTS project offered me an opportunity to re-experience what I thought I had rejected before in TOTIS, I was eager to return. I watched with fascination as the City TOTS faculty, most of whom have national reputations as "experts," developed the training agenda and worked together. I watched their fears emerge. I was absorbed as they willingly walked into the murky conceptual waters most practitioners avoid and was comforted by their struggle to accept ambiguity. I shared in their sense of completeness when a unique training opportunity came off (at least partly) as they collaboratively imagined it.

My experience of City TOTS parallels what practitioners in direct service should experience. With supervision, mentorship, and the support of our colleagues in a professional community, we can be open to our fears, uncertainty, and ambiguity. In a collaborative setting, which includes families, we can create new opportunities for children.

I currently provide inservice training to parents and service providers who work with infants and toddlers with special needs. While I do not offer training as complex as **ZERO TO THREE**'s TOTIS or City TOTS, I do incorporate some of the concepts I learned from those experiences. Training is focused towards the development and collaborative efforts of regional trainers and consultants. Regional in-service training includes opportunities to explore some of the issues raised in this article, and these opportunities are welcomed by practitioners and parents who have been struggling for some time with the complexities of our common work. What it all comes down to is simple, yet elusive.

If I say that I am an expert, registered, occupational, certified, neurodevelopmental pediatric, trained, baby therapist, with 18 years of experience (and a mother of two), I create an image for the reader. It tells you something about me. But this list of professional qualifications will not help you to understand how I relate to a child, to a family, to all the other practitioners I meet. What has become critical to me occurs in the moment of interaction. It is more important to entertain the questions, "Were you kind, compassionate, and honest in that moment of interaction? Are you respected for being a decent human being, one on one?" These are fundamental to the relationships we have with one another in the arena of early intervention.

Reflection, introspection, caution and humility go hand in hand with the conviction that one can always learn something new. Moving from the practice of skill to a full professional use of one's entire self requires looking within, making changes, and then measuring the response—in the faces of the children, parents, caregivers, and colleagues you have been working with, side by side, for so long.

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The Ounce of Prevention Fund's Developmental Training and Support Program: Building Relationships To Promote Positive Developmental Outcomes

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Just as all parents need support in raising healthy children, all direct service staff and administrators in community-based programs need ongoing support, training, and supervision in order to deliver high-quality services to children and families. The Illinois Ounce of Prevention Fund's Developmental Training and Support Program (DTSP) has worked for six years with Ounce-sponsored adolescent parenting programs throughout the state in a structured process designed to transform not only the way direct service staff relate to families to create positive change, but also the way in which a statewide program development organization relates to the community-based

The Developmental Training and Support Program uses observation, inquiry, discussion, and validation to strengthen the capacity of both program supervisors and front-line staff to learn and integrate new skills in infant/family practice. Training occurs over a period of, at minimum, two years, in the context of a highly interactive, continuous, supportive, and safe forum. In each program site, the "wheel" of training and support is intentionally "reinvented" as the model is adapted to the agency, community, culture,population, and staffing structure.

Relationships are at the center of the Developmental Training and Support Program. The model is based upon clinical and research findings that positive developmental outcomes for children, particularly in the first three years of life, are related to a mutually satisfying parent-child relationship, as well as to the early identification of and intervention with developmental problems. The model is also based on the recognition that in many programs established to serve families and communities with severely limited resources, staff are so overwhelmed by the environmental and situational crises ofparents (particularly adolescent parents) that they fail to focus sufficient attention on the needs of developing infants and toddlers, or on the parent-child relationship itself. In our experience, short-term didactic training has not enabledcommunity-based staff to redirect their services from crisis intervention to strengthening the parent-child relationship. A parallel process of support, focusing on strengthening the relationship between parents and children, between staff and parents, and between facilitators and trainees, has been much more successful. Slow, incremental, locally defined change is most often the best.

This article will describe core elements of the Developmental Training and Support Program; report focus group discussions of the impact of DTSP on program design, staff, supervision, families, and children; and address issues of replication.

Core elements of the Developmental Training and Support Program

Structure: The statewide Parents Too Soon Initiative is one service delivery program administered by the Ounce of Prevention Fund. It is a network of more than 40 community-based programs designed to improve the developmental outcomes of children of adolescent parents, as well as the lives of the young parents themselves. The design of each funded program offers home visiting, parent education, and peer support groups to each participating family. In addition, as part of the implementation of an individualized family service plan, staff conduct a developmental screening and document their observations of parent-child interaction twice a year. Staff also videotape parents and children twice a year in their homes and review the tapes with parents, focusing on the positive interactions that occur in the course of daily routines.

Ounce of Prevention Fund program specialists (Wechsler) and consultants (Bernstein and Percansky) bring the Developmental Training and Support Program to groups of 12-15 staff members, representing two or three Parents Too Soon program sites. Sites are selected based on program maturity, geographic proximity, and similarities of culture in communities served. Selecting and training staff of several sites together promotes long-term collaborative interdependence among agencies with common goals.

On-site training takes place one day each month for at least two years. Program directors and/or supervisors participate in training along with direct service staff. The same trainers work with the group throughout the two-year period. After core training is completed, trainers and staff mutually plan follow-up and support, which may involve bi-monthly or quarterly visits.

Since the structure of the Developmental Training and Support Program is designed to embrace an entire service delivery approach, the strategy of training supervisors and line staff together ensures that everyone in the program has the opportunity to explore and understand the concepts, process, and tools of DTSP. A primary role of the facilitators is to create an atmosphere of safety, in

Nancy P. Alexander

order to invite the sharing of feelings, values, experiences, reflection, and collaboration. This atmosphere is particularly important for home visitors, who work in isolation and may lose their sense of a program mission unless it is reinforced through regularly occurring group experiences. The process is explicitly designed to parallel the way supervisors should support staff and families, and the way staff should support parents and children.

Content and process: The most critical content of each monthly training session is distilled from discussions of the work that staff members are doing with their families. DTSP facilitators encourageparticipants to discuss what is going well in their everyday work with families, why it might be happening, and the staff members' contribution to the success they are seeing. Program staff are required to bring fresh material about the families they work with to each session. As staff describe their interaction with specific families, facilitators can integrate information about core issues of child development and the parent-child relationship into the discussion, along with related themes, such as dealing with separation and loss or developing effective strategies for working with grandparents. Maintaining a focus on participants' direct work with specific families encourages growing clarity among staff about their role. Were we to abandon this consistent focus, training sessions might raise issues out of context and without achieving any resolution applicable to ongoing program work – much like the scenario of families in perpetual "crisis."

The continuity and consistency of the DTSP training forum reflect the process of an ongoing helping relationship. Trainees, like parents, are given opportunities and time to internalize new skills. Mutual development of the training agenda, beginning with the first day, establishes the expectation that trainees will take significant responsibility for its outcome. Facilitators get to know training participants' strengths, needs, special talents, what they know, and what they do not know. Continuity of the training group and format over time allows the reinforcement and internalization of a "new way of doing business."

Important topics and issues can be continually revisited (as they are in a therapeutic relationship.) Facilitators can respond flexibly to the ever-changing immediate needs of staff without losing sight of larger goals.

DTSP training is experiential, involving discussion of videos that show parent-childinteraction around daily routines and videos of home visitors in interaction with parents and children. Discussion of both types of videos models for both direct service staff and supervisors the process of identifying and building on strengths. Facilitators model with trainees the kind of empathic and reciprocal interchange expected of staff when they work with families. Participants are encouraged to reflect on aspects of their personal and professional relationships that enhance positive growth and development. The parallels between training sessions and home visits with families, especially the intermingling of content and process, are noted, so that the group can observe and gain insight through the parallel process to benefit their ongoing work.

Tools for observation and intervention: DTSP trains paraprofessional staff in the use of three tools which enable them: 1) to enter the world of the parent-child relationship and 2) to share insights and information with families, supervisors, and co-workers. These tools are particularly useful in home-based services, where much of the work is done by individual workers in the isolation of participants' homes.

● **The Parent-Child Observation Guides (PCOGs)** are recording forms developed by Victor Bernstein, Candice Percansky, and Sydney Hans to help staff objectively organize their observations of parent-child interaction. The *Guides* and accompanying manuals identify areas of relational behavior – for example, involvement, security, learning, enjoyment – that support development in children. Staff learn to use the guides to: 1) observe and understand parent-child communication; 2) identify specific strengths in the parent-child relationship; and 3) plan with parents ways of building on the

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strengths of their relationships with their children.

● **Training staff to videotape** parents and children engaged in the daily routines of their lives and themselves interacting with parents and children has proved to be DTSP's most powerful means of teaching observation skills. Videosprovide a vehicle for translating and integrating information not only intellectually, but affectively as well. The videotapes that staff make of each family twice a year are a concrete means of helping parents focus on how they and their children communicate. They are also an important tool (especially in home based services) for staff supervision and skill development.

● **The Denver Developmental Screening Test (DDST)** is used in the context of DTSP as a developmental **demonstration** tool, to help both parents and staff focus more directly on children and on parent-child interactions. Parents and staff administer the Denver jointly and together review the child's demonstrated capacities, discuss skills and abilities that will be emerging shortly, and talk about age-appropriate activities that encourage development. Parents enjoy the process, often expressing pride in how much their child is able to do. Joint parent/staff administration of the DDST, especially with teen parents, reinforces parents in their role as the "experts" on their children and reduces anxiety about children's test performance.

Supervision and support: The DTSP is built on the premise that just as parents need support and skills in building relationships, so do providers. For this reason, supporting supervisors and program directors is central to the model. The involvement of supervisors and program directors not only determines the success or failure of DTSP training but overall program integrity as well.

The relationship of the Developmental Training and Support Program and its staff toprogram sites grows out of the relationship that the Ounce of Prevention Fund, as program developer and funder, establishes and maintains with program sites. Once training begins, the director or program supervisor and the Ounce specialist or consultant are in regular contact, at the time of each monthly training session and between sessions. Supervisors can process and problem-solve issues of sharing one's work that have emerged in their own supervision of site staff. The DTSP facilitator can encourage the supervisor's active participation in, and responsibility for, any site-based preparations needed for the next training session.

As participants in DTSP training sessions, supervisors learn alongside direct service workers the skills of objective observation, identifying and supporting strengths, and inquiry. These skills structure supervisors' work with staff, much as they structure staff's work with parents. While direct service staff practice and experiment with new tools and strategies for observation and intervention, directors and supervisors begin to transform program administration to better match the relationship-based philosophy and goals of DTSP.

It is important to note that regular individual or group supervision was previously characterized by case management and administrative "housekeeping" in most Parents Too Soon programs prior to participation in DTSP. The DTSP training sessions, supplemented by technical assistance from Ounce specialists, help supervisors understand the importance of: 1) keeping caseloads small enough to enable staff to establish meaningful and productive relationships with parents; and 2) supporting these relationships through frequent, regular and reflective supervision with staff, individually and in teams.

After the initial DTSP training program, when sessions become bi-monthly, the Ounce facilitator meets on the alternate months with the program director or supervisor. These meetings are used to focus on ongoing supervision issues; reinforce consistent use of DTSP philosophy, strategies, and activities; and support the supervisor's ongoing training of staff. This is a process that transfers responsibility for establishing the tenets of the DTSP from the Ounce to the local site.

A focus-group self-evaluation of the DTSP

In the summer of 1992, we convened a series of focus groups of program directors, home visitor supervisors, home visitors, and teen parent participants in Parents Too Soon programs. Our goal was to understand the impact of the six-year-old Developmental Training and Support Program by reviewing with our constituents changes that they had seen in program design, staffing, supervision, and experiences of families and children. The focus groups we convened matched the ethnic, racial, and socio-economic diversity of the conglomerateprofile of Parents Too Soon programs across the state, as well as the mix of urban, suburban, and rural communities served.

Focusing attention on the staff-parent relationship: Impact on workers

We have finally learned there are issues that we can deal with and issues we can't. We are much clearer on what our work is and what we do: it's all related to the parent-child relationship. We're stillconcerned whether moms are in school, or if they're evicted and need housing. We help them with that. But there were times in the past when we ran around in circles over things we couldn't do anything about. We don't do that any more.

– Home visitor focus group participant

The urgent needs of teen parents demand response. Home visitors, wishing to address these needs but also aware of the importance of attending to children's development and to parent-infant relationships, often

express frustration and anger – sometimes toward the adolescent parent and sometimes at the economic and social conditions that constrain the teen parent. Some home visitors deal with their empathy with adolescent parents, their own need to see positive change, and their anger by helping teens manage immediate crises. Unfortunately, this response tends to trap home visitors in a cycle of crisis and frustration.

In contrast, when DTSP facilitators help home visitors to focus their attention on the staff-parent relationship, renewed energy and enthusiasm for the work result. Home visitors and adolescent parents grow in their ability to communicate, trust each other, and gain mutual pleasure from their interaction. Home visitors and their supervisors describe "a veil being lifted"; they see a sense of direction and meaning in their efforts. Most importantly, both workers and parents are more satisfied.

Focusing attention on relationships: Experiences of parents

My home visitor made me realize what I was doing. She gave me information about why the baby was pulling my hair – because she was playing, not because she wanted to get me mad. My home visitor got me to learn exactly what the baby was doing and what it meant. Now I can tell the difference.

– Teen mother

In their focus groups, teen parents told us that the most important benefit of their participation in a Parents Too Soon program was learning about the expectable stages of their child's development, so that they could read the child's signals and communicate better with the child. They told us chilling stories of experiencing their infants or toddlers as tormentors and wishing them dead. Home visitors helped these adolescent parents make sense out of a maddening experience; teens could see direct links between their new abilities to understand and communicate with their young children and the improved health and safety of the children – and themselves.

Young parents said that the connectedness they felt in their relationships with their home visitors often brought calmness from chaos, pride in their own abilities, and the emergence of direction for the future. Most importantly, teen mothers reported a learned and experienced sense of their child as a separate individual with his or her own needs. Adolescent parents felt that the rewards from their program participation were so meaningful that they invested willingly in the relationships offered and responsibilities expected by home visitors.

Appreciation of the helping relationship

I think it's great that someone can come into my home and be close to my daughter, almost as close as I am. She isn't trying to only help me, but is learning how my daughter is. It makes me feel good.

– Teen mother

In focus groups, home visitors reported uniformly that their greatest asset in working toward a better parent-child relationship and satisfactory child development outcomes was the strength of their relationship with the teen parent. Home visitors all reported having their greatest sense of success with teens who they believed felt accepted by them. Once a sense of acceptance was established and consistently demonstrated, the home visitors reported, they felt they could enter the family as a support and an observer, and intervene as a helper.

Teens also gave importance to the nature of their relationship to their home visitors. They talked about being accepted unconditionally and experienced their home visitors as genuinely interested in them. Teens could describe specific occasions on which home visitors had valued their abilities and talked about what was "right and good" about them and their parenting rather than about what was wrong. They valued having someone to talk with who really cared, and who would openly share something of herself with them.

Training and interventions based on observation and inquiry

At times, the training seemed to go so slowly and take so long. We program staff would talk among ourselves: Why won't they (the Ounce facilitators) just come in here and tell us what to do? (Now we realize that) they intentionally modeled for us how to figure out on our own how these skills and information are going to work in our own program, so that we would have ownership. In the end, it was probably better. (We could translate the DTSP approach) into supervision and home visits – not imposing information on people, but giving them information, tools, and support to come up with some of these things on their own.

– Program supervisor

Adolescent parent participants in Parents Too Soon programs are often veterans of many "helping" programs. They tell us that one thing they like about Parents Too Soon, something that is different from many other programs, is that staff don't tell them what to do or how to live their lives. Rather, the program tries to help young parents through a process which results in their deciding how to live their lives.

Home visitors, supervisors, and directors hope, of course, that as a result of their participation in Parents Too Soon programs, teen parents' decisions will be made in the best interests of themselves and their children. The home visitor's work is to find effective ways to maintain the parent's role as the ultimate authority in her child's life, while assisting the parent in gaining a greater understanding of her child's needs.

DTSP activities invite the teen parent to step back from everyday demands and to formulate her own perspective and understanding of her interaction with her child. Administering the Denver Developmental Screening Test, watching a video made in the home, and reviewing observations recorded on the Parent-Child Observation Guide all afford opportunities for parents and staff to better see and understand a child's abilities and behavior, as well as to celebrate the strengths and achievements of the parent-child relationship.

When trust, respect, and openness characterize the parent-staff relationship, these activities can also serve as a springboard to explore concerns or discomfort. Any intervention is based on inquiry. The DTSP teaches staff not to assume anything, but rather to ask questions in an effort to gather more information collaboratively, in order to develop with the parent a common understanding and to chart a path of action. Home visitors can be more effective as sources of accurate information and dependable guides for teen parents than as didactic "advisors" or "fixers."

Supervision

I think what we have learned through the training is not to discount whatever crisis the family is going through, to certainly address it, but to also address the issue of how this is affecting the child and the parent's relationship with the child.

— Home visitor

The DTSP...provided a common ground for the home visitors and supervisor—...a very positive thing for my relationship with my staff.

— Home visitor supervisor

Program directors and supervisors of home visitors reported that prior to receiving the Developmental Training and Support Program at their site, supervision was typically focused on a crisis experienced by a teen mother, her child, and the extended family. Seldom, if ever, had supervision focused on the worker's needs or her relationship with a teen parent. As home visitors began to focus on the parent-child relationship and the support of strengths as a basis for effecting change, they brought different material and issues to supervision. Home visitors could reflect on the observations they had made during home visits and review Developmental Screenings, videotapes, and PCOGs with their supervisors, as well as with parents. Workers and supervisors could **plan**, not simply react to immediate emergencies.

Joint participation in the DTSP by front-line staff and supervisors was critical to this shift in the supervisory process in two ways. First, home visitors and supervisors now shared what they often referred to as a "common ground" of knowledge, trust, and mutual admiration for each other's ability. This common ground gave both permission to explore not only the behaviors and interactions of families, but also of themselves and each other. Second, supervisors brought into supervisory sessions the same rules – of never assuming anything, of addressing questions and concerns by asking questions, and of intervening through a process of building on existing strength – that home visitors were implementing in their work with families. Supervisors were rewarded as workers talked less about problems and crises and more about what parents were doing well, how they had planned and intervened, and how mothers and children seemed to grow from a greater sense of "connectedness."

Impact at the program site and beyond

Usually you get the money and you are on your own. I have never worked in a program where the funding source has been this supportive. If we had not participated in the training, we would have been lost. I think trust with the funder is the important thing. Because there are relationships with real people. If something is not going well, I can certainly trust that I am going to hear about it and be given the tools to make a change for the better.

— Program coordinator

What are the signs that training has "taken hold" in a program? The most obvious indication is that the goals, services delivered, and outcomes for participants are better matched to the population being served than before. In addition, where training has "taken," staff members report feeling more positive about the work they are doing and clearer about their roles and the impact they are having on families. Correspondingly, families have experienced more success as a result of their participation in the program. Perhaps the most significant indicator of a "good take" is the ability of a program that has experienced training to carry out the training process for another program. Not only does this reflect the strength of the initial program's "ownership" of the training and support model; it makes a strong statement, as well, about the program's ability to build upon it and extend it.

Since its inception, the Developmental Training and Support Program has been in a dynamic process of being defined by, and at the same time redefining, the Ounce-funded Parents Too Soon service design. The results of these processes can be seen on several levels. First, the conception of home visiting itself has changed. Initially seen as an outreach approach, home visiting is now viewed as a core service delivery strategy, with guidelines for best practice established and required of all Ounce of Prevention-funded programs. At another level, the Developmental Training and Support Program's experience has led the Ounce to give funding priority to program activities which focus on strengthening the parent-child relationship and positive developmental

outcomes for young children. Finally, directors of Ounce-funded programs tell us that the sense of partnership achieved through the DTSP training relationship has established a sense of shared vision between them and Ounce management. Over the years of DTSP participation, directors integrated knowledge into their practice and experienced respect and investment in them and their programs. They came to believe that the Ounce was not only a funder and monitor, but also a partner committed to their programs, their staffs' professional development, and ultimately to the children and families in their communities.

Selecting programs to participate in intensive training/development efforts

We have identified six criteria that seem to predict a service program's likelihood of being able to make good use of an intensive, long-term, relationship-based model such as the Developmental Training and Support Program:

1. The program's design and structure, including the leadership and staffing pattern, must be intact. The program should be fully staffed and have had little turnover over a reasonable period of time.
2. Program administrators and staff must share a perceived need and interest in focusing upon the specific issues of child development, parent-child relationships, and supervising/supporting program staff in a new way.
3. Supervisory and front-line staff at the program site need to express willingness and interest in working closely with Ounce staff/consultants and to join with them as partners in a long-term training and program development effort. They must see the process as one of learning and discovery, be willing to share agenda-setting, and commit to attending all training sessions.
4. Program administrators must be as committed to providing training and supervision of staff as they are to providing direct services to families.
5. The program director and/or supervisor(s) must commit to attending training sessions regularly and on an ongoing basis.
6. Any program that serves infants, toddlers, and their parents must have demonstrated strong enough linkages with local primary health care providers and early intervention resources to en sure appropriate referral and follow-up of children and families with special needs.

Lessons learned

As we have made efforts to adapt DTSP beyond Parents Too Soon programs, to other prevention and early intervention efforts within Illinois, in other states, and in Latin America, we have found that the need for training in the context of continuous and supportive relationships exists in virtually any community program serving young children and their families. However, we have also discovered that particularly in the poorest, most complex communities, consuming environmental issues make it extremely difficult for staff to develop or sustain a focus on the strengths of the parent-child relationship. Once consultants/trainers are no longer involved, highly stressed programs return to a familiar "crisis mode" ofservice delivery. Few states or local initiatives have been able to offer infant/family programs the structural support needed for long-term positive change.

What we have learned about training through DTSP is what we know about change itself: It is a slow process, requiring commitment, resources, and continuing reinforcement. As a home visitor once reminded us, "When we let go of the mom's hand, she lets go of her child's." No program development and training effort is ever really "finished." Just as families continue to need varying levels of support throughout their lives, so do the programs—and the people—who support families and their young children.

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Linking Knowledge and Experience: A Model for Training Infant/ Toddler Caregivers and Infant Mental Health Practitioners

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Work with infants, toddlers, and their families demands from practitioners the ability to build relationships, the ability to demonstrate flexibility and openness to the many aspects of diversity, the ability to develop critical thinking and divergent problem-solving skills, the ability to be creative, and the ability to support the uniqueness of each infant and his or her family. A program designed to train adult learners to meet these demands needs to reflect and demonstrate the same values it requires students to embrace and practice.

At the Canadian Mothercraft Society, we have developed a set of key principles that drive both the theoretical, academic component and the practical field internship of our 12-month training program for early childhood practitioners. We design curriculum content and teaching methods to incorporate these key principles at each stage of the training process. Our goal is to create a model which allows students to clearly link acquired knowledge and their own experiences. We strive:

- to support the uniqueness and integrity of each individual student;
- to nurture each individual's sense of security and self-esteem;
- to develop risk-taking, flexibility and creativity;
- to develop critical thinking and divergent approaches toproblem-solving;
- to encourage ownership for self-growth through self-evaluation and active particip-tion; and
- to value and respect all aspects of diversity, including differences in race, gender, culture, age,sexualorientation, social class, and religion.

This article will illustrate our efforts to incorporate these principles in the structure of our learning environment, the selection of applicants for training, the integration of content and process in the curriculum, and the design and implementation of students' field internships.

The learning environment

Creativity and risk-taking can be nourished and sustained only in an atmosphere of trust and high regard for the integrity of each individual student. We keep our infant/toddler caregiver classes small, with no more than 30-35 students, to allow for individualized support and nurturing. The staff-student relationships developed through individualized monitoring and supervision both inside and outside the classroom become internalized by the students. As students' self-esteem and self-confidence grow, so too does the trust between students and faculty, between students and students, and between students and young children.

Selecting applicants for training

Pre-service training of infant practitioners begins when applicants for admission to a training program are interviewed. We use the occasion of the interview to identify the presence or absence in an applicant of significant personal qualities related to professional performance. During the interview, we present candidates with a variety of tasks that elicit creativity and divergency of thought. For example, presenting a candidate with hypothetical situations dealing with potential peer conflict in the academic classroom elicits a glimpse into the student's capacity for tolerance, empathy, and openness to new ideas – or, as the case may be, the student's judgmentalness, rigidity, or inability to accept individual differences. The applicant's responses to typical behavioral situations found in child care not only reveal her intuitive knowledge of child development, but also her ability to analyze issues, apply ideas, and become aware of personal values.

During the pre-admission interview we also give applicants a number of homemade toys that can be used in a variety of ways. As candidates analyze the play objects for intrinsic skill-building opportunities, they demonstrate, in varying degrees, creativity of thought. We have learned over time that applicants with more rigid, reserved, non-divergent approaches to this exercise tend to have difficulty being open, responsive, and flexible in their interactions with infants. Conversely, those candidates who, with animated facial expressions, demonstrate an uninhibited, detailed exploration of the toys and offer multiple suggestions for their use are more likely to have a personality that enables them to support the emotional and physical development of infants and toddlers.

Integrating content and process in the training curriculum

The major dimensions of our training curriculum include:

- knowledge of infant/toddler development, including observable milestones and theoretical conceptualizations of developmental progression;
- knowledge and skills needed todevelop an interactive curriculum to optimize the infant's growth from birth;
- application of knowledge and skills in a variety of settings, with individualized supervision;

- knowledge and skills involved in working with families (for a discussion of this dimension, see Fenichel and Eggbeer, 1990).

In order to integrate content and process along each dimension of the curriculum, we use a variety of training methods. Demonstration, role playing, observation, analysis of play behaviors and evaluation of caregiving strategies/interactions each give the student a fresh opportunity to integrate theory and practice, and to practice and refine skills.

The wealth of information related to infant development can be overwhelming, both to the student who needs to learn it and to the faculty who needs to teach it. To cope with constant tension between "covering as much content as possible" and "assuring mastery of knowledge," we have identified a set of core skills that students can be expected to achieve. We choose instructional methods that challenge students, while they are applying themselves to the study of child growth and development, to acquire the following skills:

1. Identify emerging developmental competencies in the child, as well as those already mastered;
2. Observe and analyze cognitive strategies and intent demonstrated by the infant during play;
3. Evaluate the range of strategies available to the caregiver that can support, extend, and enrich developmental experience;
4. Interpret behavioral and communicative cues to achieve mutual effectance (mutual effectance occurs when adult and infant provide themselves with contingent experiences;
5. Assess how the physical environment promotes and supports developmental needs of the individual infant as well as the group;
6. Identify different temperaments and establish ways of relating that promote mental health for each individual infant.

Subjects & Predicates

Our efforts to match instructional method to core skill are illustrated by our approaches to teaching developmental skill progression and observation of the infant/caregiver dyad.

Teaching developmental skill progression through toy demonstration

We use toy demonstration to teach developmental skill progression. Using primarily homemade toys, our trainers help students to identify what competencies infants are practicing in their play and how sensory schemas are being combined. This method allows the trainer: 1) to demonstrate how a variety of toys supports the practice of the same developmental concept, and 2) to elicit from students how a single toy allows the infant to practice a variety of skills. For example:

- Open-and-find containers, peek-a-boo puppets, pop-up surprise boxes, a ball in a tube, and play with blankets and mirrors all give the infant opportunity to experience object permanence.
- A pound-a-ball bench with a ramp allows the infant to learn about object permanence, cause and effect, spatial relationships, and color matching, while practicing eye/hand coordintion.

Playing with the materials themselves, students reinforce their understanding of the multi-purpose, multi-level, and multi-sensory nature of toys.

Assigning students to design their own toys challenges them to creatively synthesize their new developmental knowledge. (The degree of panic among students receiving this assignment ranges from minimal self-doubt to visible anxiety. However, creativity usually conquers panic, and a tone of confidence emerges in the class). Despite the emotional stress of the task, students invariably produce original toys or toys with original features. As each student presents her toy to the class in a non-competitive atmosphere of sharing and teaching, both faculty and students recognize the wide variance in individual strengths and divergent ideas. One year, the class produced so many innovative infant toys that we compiled a book, complete with photographs. This collaborative venture helped create a strong team spirit among the students, as well as a significant extension of our collective knowledge.

We reinforce the toy exercise by having infants and toddlers visit the classroom and play with the toys that the students have made. (We are fortunate to have a lab school on the same premises as the training facility. In other settings, I have invited parents with children between the ages of 5-24 months to participate in this class exercise. One benefit of this approach is the opportunity for students to observe and discuss parenting styles and parent/infant interaction issues.) As students observe children playing with their toys, they commonly express both pride and surprise as the infants and toddlers play with the toys in ways that were never in the original "design." This hands-on experimentation also emphasizes how toys can be used in variation, to match the infant's ongoing skill development. Watching the interactions between infants and toys, students can identify and relate observed behavior to the theoretical constructs they are learning and raise questions as well.

Role-playing is another way to stimulate students' awareness of the different levels of involvement that infants display in play. Students can be paired, or the teacher may assume one role in the pair, to simulate action between infant and caregiver. This exercise reviews behavioral patterns for certain stages of development and also sets the stage for reading communicative intent (see core skills 2, 3, and 4 above). While one student uses the toy to role-play an infant imitating, taking the lead, or feigning disinterest, the other student will work through the caregiver's task of creating an appropriate "fit" between the infant and available play materials.

Much laughter and good humor are evident as the group watches the responses of one student to the antics of another, who is role-playing a petulant toddler firmly exercising autonomy of choice. Any number of games can be used to reinforce the concept of the infant as an active partner in his or her social environment. Students need to be particularly sensitized to the importance of recognizing and respecting an infant's bid for self-initiated exploration.

Teaching observation skills

Learning to observe is critical for infant practitioners. Students need extensive opportunities to observe,interpret, and analyze infant/caregiver interaction and play behavior. It is through observation that students link the two perspectives of the infant/caregiver dyad. When students focus their attention on the caregiver, they become more sensitive to the factors involved in creating and sustaining a responsive relationship.

Live observation in infant/toddler rooms in lab schools and/or child care centers and review of video footage allow students to complete and evaluate numerous running records. The focus for each observation can be directed toward specific training objectives:

Subjects & Predicates

Observation of the child (core skills 2, 4, and 6): identification of cognitive strategies used in play; identification of types of play (e.g., trial and error or exploratory play, mastery, sensory pleasure); identification of relationships being constructed between infant and object; identification of ways of expressing emotional needs; analysis of communicative cues and intentionality; identification of individual variations in development; differentiation between attachment and exploratory behaviors.

Observation of the caregiver (core skills 2, 3, and 5): identification of strategies used by the caregiver to support, extend and enrich the child's developmental experience; analysis of the factors in the physical and social environment that hindered or facilitated the interaction; identification of verbal and non-verbal communication; evaluation of the reciprocity within the interaction; analysis of cues that were missed.

These observations can be integrated into courses dealing with behavior management, child development, working with families, and curriculum planning. Observations should also be part of the field internship practicum.

Relationship-based curriculum and program planning

Elizabeth Jones (1984) connects relationships and learning this way:

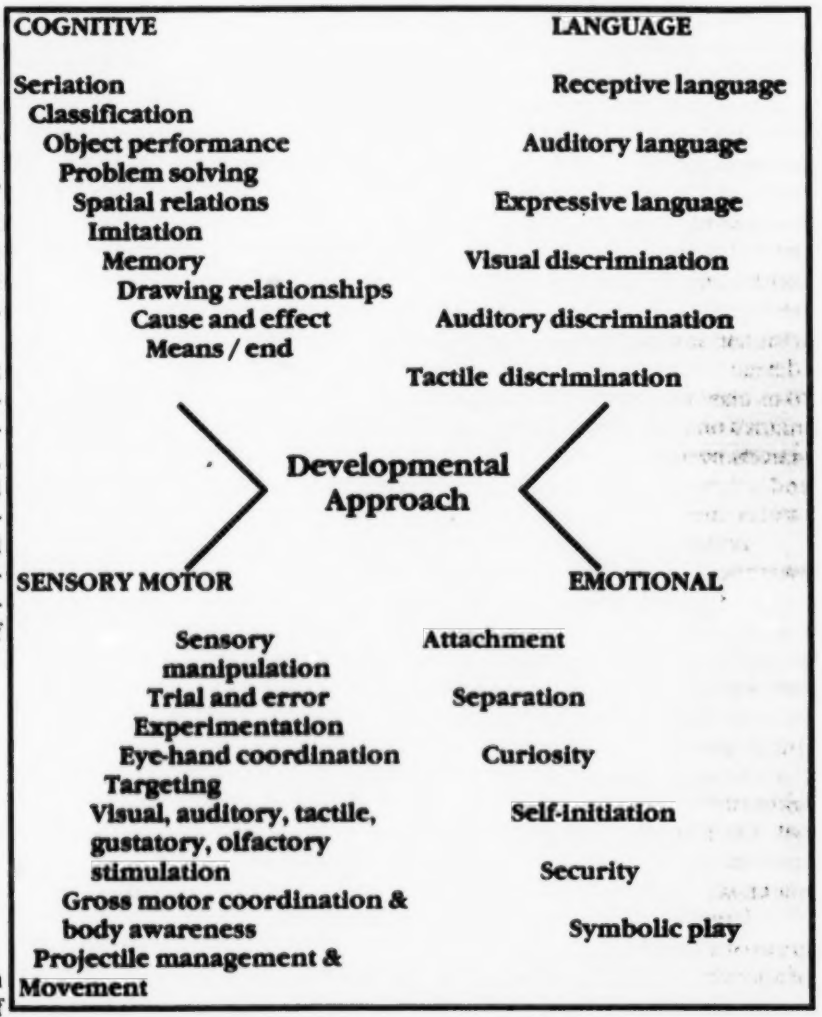
Relationships are...central to teaching and learning: my task as a parent, preschool teacher or caregiver is *to get to know this child* and *to get to know myself* in the context of the environment in which we find ourselves. Our mutual learning grows out of our shared relationship (p. 187).

Once students understand this basic premise, the task of designing a curriculum for infants and toddlers flows more naturally. Students must learn that "curriculum" for infants is a dynamic, spontaneous interactional system (Flint and Hall, 1991). They must shed the image of themselves as didactic enlighteners and accept the role of facilitators, who will guide and support the infant through the complexity and stresses of developmental growth.

Curriculum for infants is not a box full of prescribed "activities" or a misguided effort to "teach" preschool concepts such as numbers, letters, shapes, sizes, and colors. But curriculum does need to be mediated by an adult. Upon accurately reading an infant's cues, the skilled practitioner provides developmentally appropriate responses, either through objects or social interactions. Facilitators of infant care need to recognize that:

- The daily occurrences in the lives of very young children serve as curriculum opportunities;
- The integration of caregiving routines and learning constitutes quality infant curriculum; and
- The core of the curriculum revolves around building relationships and developing attunement to emotional needs.

"Webbing" is a form of curriculum planning which integrates a variety of experiences, all of which serve to present a single concept. The concept is explored through a series of developmentally appropriate activities, each reflecting and interweaving an extended relational idea. Each thread of the web can be enriched and expanded to assist the child's growing understanding of his or her world and how he or she is a part of it. In a pre-school setting, webbing would link the concept of "water," for example, to weather, transportation, occupations, uses, physical processes, and bodies of water, with planned activities linked to developmental learning outcomes such as problem solving, sequencing, patterning, relational thinking, symbolic play, perceptual/motor skills, and language experience. In the context of infant/toddler work, however, webbing takes on a different guise, as students plan learning experiences and seize upon the numerous spontaneous teachable moments that arise in the course of daily interaction. The web below represents types of infants' learning experiences, in cognitive, language, sensory motor, and emotional domains.



Given students' varying knowledge and skills, we find it helpful to have the whole group brainstorm a week's program of activities, using this developmental planning approach, before submitting the actual assignment. A discussion of how planned activities can be modified to accommodate a wide range of infant abilities makes students more aware of the developmental distinctness of each child. This theoretical assignment is then "reality-tested" when students implement their ideas for activities during the field practicum. It is then that students are called upon to critically evaluate the developmental appropriateness of their curriculum planning.

The field practicum

The field-based component of our training program is perhaps more critical than classroom learning. This is the time when direct experience and skillful supervision enable students to make a meaningful connection between theory and practice. It is in the field that a student experiences a moment of epiphany and cries out, "I had this terrific sensory activity all prepared, but all the babies did was cry and want to be held!"

Field practice should be designed to support the primary task of training, enabling students to build rela-

tionships with infants and toddlers. A practicum at least six weeks long, carried out in daily, eight-hour blocks of time, promotes a sense of continuity and a basis for trust-building between students and children and between staff and parents. Written assignments given to students to complete during the practicum should be vehicles for critical thinking, application of classroom learning, and self-evaluation.

Applying knowledge of developmental sequence

In the field, students can use developmental checklists to strengthen their understanding of developmental sequence. Students should observe, record, and interpret data on infants and toddlers of various ages. During the course of this assignment, students will become able to identify quickly individual variations in patterns of development. Several developmental checklists are available to trainers. We have developed an amalgamation and adaptation of the Brigance Diagnostic Inventory of Early Development (1992), the Hanen Language mode (1991) and Stanley Greenspan's model of emotional milestones (1990) which provides a very thorough practice tool for our students.

Designing an individual program plan for a child, based on the completed developmental checklist, is a worthwhile complementary exercise. This type of assignment extends students' ability to interpret and evaluate their observations, identifying and categorizing behavior as developmental "strength" or "weakness." Based on these analyses, students then create a plan for both appropriate and supportive developmental activities and environments for individual children. The next step is to implement the plan. The six-week placement allows the student an opportunity to evaluate the success of the plan, at least over the short term.

Students bring all of the material they compile in the course of observing and assessing during the field placement back to the classroom. Here it becomes a foundation on which to construct a more detailed case study of the infant/toddler.

Understanding and modifying the impact of the physical environment

The field practicum is an ideal context for students to learn how the physical environment affects an infant or toddler's play. The Harms Infant/Toddler Environment Rating Scale (1990) can be adapted for students, to introduce such fundamental environmental concepts as softness and comfort, privacy, safety and health, mobility and risk-taking, quality of social interactions, and routines and security.

During the field practicum, we assign students to design and implement "room goals." These reflect the student's analysis of the environmental components present in the field setting and suggest modifications likely to improve the environment's ability to support the development of the age group of children being served. Over the years, students' room goals reflect the individual differences in experiences and abilities that they bring to the training program:

- **Some students identify and implement goals related to overall administration of a child care program** —e.g., designing and posting a list of children'sallergies to help orient students and new staff;warming face cloths to make infants more comfortable when being wiped before and after eating; attaching pacifiers to children's clothing with ribbons and safety pins, to decrease loss and increase cleanliness.
- **Others find physical modification of the environment safe and relatively simple to carry-out** – e.g., draping a curtain in front of a recessed area to increase privacy, and adding different textures on the inside walls and floors; making individual books for each toddler with pictures of family and special objects; dressing dolls in hats, bibs, and snowsuits to introduce more elements of softness to toddler toys.
- **Still other students focus purely on developmental supports** – e.g., creating and displaying an "emotions poster" and engaging children in conversations on feelings; providing new and different utensils and props for fine motor practice in the water and sand area; bringing in books for toddlers that address autonomy *(The Runaway Bunny)* and separation *(Are You My Mother?)*.
- **A small number will address the importance of relationships and social interactions** —e.g., coordinating the staff team to ensure that transition between play and outdoor readiness time will be as stress-free as possible for the infants; evaluating the temperament of individual infants and using findings to make recommendations around interactions for new staff and students; being sensitive to opportunities for group activities when children cluster spontaneously.
- **Many students remain self-focused, as they a tempt to master competencies**—e.g.,being aware of repeating and extending infant vocalizations; asssessing, while scanning the whole room, when to engage a child in one-on-one interaction or to assist other team members; being more assertive in mediating and intervening in outbursts of aggression.

The room goal assignment is required during both the infant and toddler field practica. It sensitizes the student to the interplay between environmental factors and ongoing human development.

Role modeling and reflective supervision

The success of a student's field internship depends on the quality of role modeling and reflective supervision available. Regular staff in a child care setting

may be wonderfully gifted in working with infants, but are not necessarily skilled in facilitating the learning of adult students. It takes time and effort to support students in their problem solving, to provide feedback that extends opportunities for students to assess strengths and limitations, and to communicate honestly and nonjudgmentally. It would be unfair to delegate these responsibilities wholly to staff in the practicum setting – not only because of the work involved but also because students can deal with self-assessment and personal goal-setting more comfortably and honestly with a trusted faculty member than with a relative stranger.

Faculty of the training program must observe students at regular intervals during their field placement and support them through periods of individualized reflection. If a student appears to be struggling, a video of her interactions with the children can become a powerfully effective supervisory tool.

Another vehicle for reflection are the integrative seminars that we hold in the classroom two or three times per six-week field placement. These sessions become forums for analyzing issues, brainstorming solutions, and generating coping strategies to take back to the field experience. Although faculty facilitate the discussions, much of the real teaching comes from the students.

One of the more memorable examples of such teaching occurred when a number of students shared their despair at the "possessiveness" demonstrated by toddlers in their care. Students were finding it increasingly difficult to mediate disputes and to encourage sharing among the children. One extremely attuned student laughed and exclaimed, "They are hoarders, and what they want to do more than anything else is to collect and hoard. So I let them." The student then explained how she supported one particular toddler's need to collect by providing multiples of toys and all sorts of containers (shopping bags, purses, baskets, boxes, and even a suitcase.) She reported that the toddler would sort the toys uninterruptedly for 30-40 minutes. When the student finally asked, "Which stick will you return to the table for the other children – the popsicle stick? or the wide one?," the toddler labeled the items she would happily and unselfishly.

The developmental dilemma was solved with an easy and creative idea. More significantly, students were taught by a peer that sensitive observation of children's behavior can reveal logical, responsive solutions. Peer modeling can be more powerful than academic lecturing. Where appropriate, it should be supported.

In sum...

Love for children can no longer be the sole prerequisite for employment as a professional infant/toddler practitioner. As research continues to inform the field about what constitutes quality caregiving, trainers need to reconceptualize what constitutes quality training. Trainees, for their part, need to recognize that their primary professional responsibility is to build a relationship with an infant and his or her family.

For many students, the image of the "teacher" has a strong appeal; the role of "mediator" appears less glamorous. The challenge to the trainer, then, is to help students realize the importance of attunement and creativity. To support an infant successfully in his or her individual passage through developmental processes, with all their twists and turns, can only be accomplished through sensitive analysis ("What is this baby **feeling**?") and creative, reciprocal responsiveness ("How can I meet this emotional/physical/cognitive need of this infant at this time?")

A fitting conclusion to this essay can be found in the words of a student:

When I first started studying, I would attribute a child's behavior to his having a bad day, or the weather. I would label superficially. After eight months of training, I find myself wanting to know what's happening to the baby – why is she so upset? What can I do? Or I find myself delighting in an infant's curiosity, or a certain movement...

A new relationship has begun.

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Personal Narratives and the Process of Educating for the Healing Partnership

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Helping young children "at risk" due to diverse and complicated factors—prematurity, medical fragility, neurodevelopmental disorders, environmental deprivation, maltreatment—touches our emotions as well as our intellects. Professionals devoting their careers to young children and families must cope with heart-wrenching situations and insoluble ethical conundrums. Throughout their professional lives, they will repeatedly experience a full range of feelings—disturbing and humbling as well as gratifying and affirming. Given the inherent difficulties of professional practice, how can we nurture empathy for children and families, understanding of our colleagues, and acceptance of our own uncertainty and vulnerability? Given the daily strains and stresses, how can we promote qualities of valuing tolerance, compassion, and self-reflection—the bedrock of empathy for children and parents? How can older professionals—supervisors, directors, mentors—help newly-minted practitioners to refine—or redefine—their roles and expectations in order to achieve a healing partnership?

We authors believe that the use of first-person narratives – "stories" – from both parents and professionals can encourage the reflection and discussion essential for empathic professional practice. Stories provide a blueprint for expanding our own perspective and awareness. Stories engage both our feelings and intellect.

For whom are these stories intended? Traditionally, supporting and educating parents have been roles left to nursing staff or specific social work professionals. That this has been helpful for parents is unquestionable, yet it is undoubtedly not enough. Repeatedly parents have made it clear that they need the same caring and nurturing approach from all the professionals with whom they come in contact, from the first moment that a problem is suspected. Thus it is critical that other allied health professionals, too, recognize their potential healing roles with families.

The need is understood, even expressed, yet the lack of formal training, the haphazard catch-as-catch-can nature of skills acquisition, the possible lack of a philosophical base, all leave this most-important role of "talking to parents"—of building the healing partnership—to chance. If the case managers, supervisors, and directors (often physicians), value the supporting, educating, caring roles which may be a part of professionals' interactions with families, then both parents and professionals are more likely to be empowered and encouraged.

Used in group settings, stories invite participants to sharpen the listening and problem-solving skills needed to reach out to families and colleagues under difficult circumstances. For students and professionals whose training has not included individual reflective supervision, engagement with the first-person narratives of other professionals and parents may suggest the value of embarking on their own journeys of deepening sensitivity and discovery.

Stories from parents

The personal accounts of parents—painful or disturbing as they sometimes might be—are a uniquely valuable resource for those in the helping professions. The process of studying and discussing stories of positive experiences may "infuse one's work with hope and a vision of the possible despite the stress and constraints locked within professional roles." (Leff and Walizer, p. 11) Examination of difficult stories may yield a positive goal: to educate for growth and change.

These stories open a window on the challenges parents face as they begin to cope with the diagnosis of a serious illness or disability in their child, manage therapies and treatments, and integrate their child's needs into their daily lives. By narrowing gaps of understanding and encouraging professionals to listen carefully, these narratives draw professionals closer to the young children and families directly under their care.

Diagnosis

The diagnosis of illness or disability in one's child presents parents with a crisis of overwhelming dimensions. Parents have repeatedly emphasized that the manner in which the bad news is presented by caregivers has a profound effect on their views of themselves, their child, and their future contacts with those helping their child.

Stories contrasting differing approaches toward parents of children with similar diagnoses and disabilities are particularly effective learning tools. The following vignettes illustrate two very different experiences:

Penny's mother: *When my eleven-year-old daughter Penny was two, we sought help in understanding why she was "different." After receiving very little information from our family doctor, we took Penny to our local university for evaluation. We were frightened—frightened for our daughter, frightened for ourselves—and in*

a great deal of pain and distress.

During the evaluation, we had contact with many professionals. Our most painful encounter within the health care system occurred with a clinical psychologist at the university. After a half-hour discussion with us about Penny, she bluntly turned to us and condescendingly asked, "What did you do to cause this child to be like this?"

We had just learned about Penny's autism, and our fears and anxieties were overwhelming. We went home and began to ruminate and wonder, ruminate and wonder. What had we done wrong? We pondered over the details of our life together, over our life with Penny: what had we done wrong?

Now, of course, I would have had a totally different reaction. At the time, however, the psychologist's brutal condemnation was devastating—a dagger through our hearts. Penny was our first child. We had waited until our lives were set. We loved her and doted on her. Needless to say, it was a very, very difficult time.

Fortunately, the director of the speech and language clinic at the university became our "guide through the maze." However, the psychologist's horrifying question wounded us deeply, and nine years later, I remember her words as if they were etched in stone. (Leff and Walizer, pp. 111-112.)

***Ryan's mother**: In our case the most helpful encounters within the health care system were with the very people who diagnosed our son Ryan, now six years old. When Ryan was almost two, we took him to our local university for evaluation after our own pediatrician refused to take our concerns seriously. A wonderful group of doctors, therapists, and counselors guided us through a lengthy, painful diagnostic period.*

A psychologist did most of the testing, including the first evaluation in our home. She was very professional, and yet we knew from the start that the cared about Ryan and our family as a whole. Since I was four months pregnant with my second son at the time, we not only were scared for Ryan, but terrified for our unborn child as well. The doctor's sensitivity and thoroughness were a great help to me during those nightmarish days.

After informing us of Ryan's diagnosis, she gave us material about autism and recommended schools in our area. Most important of all, she introduced us to some very special counselors—counselors who would be a tremendous comfort to us when no one else could be.

One of the "special" people was the mother of an autistic child who understood in her heart my fears, pain, and feelings of utter helplessness. All of these fine individuals have truly been my strength, direction, and inspiration. I owe them much more than I can ever say. (Leff and Walizer, p. 112)

The context of family life

It is important for young professionals to experience families in places and ways other than clinical settings. Services that seem necessary, programming that seems minimal, recommendations that seem essential in professional eyes, may appear very differently when viewed in the context of family life. Parental roles, while unidimensional in the context of the therapeutic setting, are in reality multiple and diverse. Young children may command a range and complexity of behavior that is never displayed in the threatening clinical situation. How can the developing professional be helped to "know" children and families more fully?

Parents themselves provide much guidance for professionals seeking to broaden, redefine, or refine their caregiving identities, most especially when these parents share their stories and contribute to education for the healing partnership. Parents' stories offer students, young professionals, and established practitioners alike a unique opportunity to step into the shoes of "the other side."

In the following excerpts, a "senior mother" (Blaine's) responds to the mother of Torey, a baby with spina bifida.

***Torey's mother**: ...I'm sure I'm not alone in feeling that if I did all the exercises and hooked Torey up to all the devices, we'd be working at it from sun-up to sunset. But, if I don't do everything, I feel guilty from sun-up to sunset. I know that we need to decide what is best for Torey, but when you're new at this you really don't know what is best! I'm hoping that we'll hear from enough parents that have already gone through this and know how some of these things worked or haven't worked. Maybe we'll hear of something we haven't thought of. Hopefully we will then have enough information to make some decisions of our own...(Jamie Hett, writing in The Bridge, Autumn, 1988, p. 4-5)*

***Blaine's mother**:...And did you ever describe our feeling so very well about either 'working' on something every waking moment (and even sleeping moments with those night splints!), or feeling guilty for slacking off! I remember when I was presented the list of all the things we should be working on at home, I asked, "So when do we go to the zoo? When do we just play?" I think relaxing and having fun and just plain being Blaine's mother have been far more beneficial to him (and me) in the long run than any particular therapy.*

We need balance in our lives so badly, and I can tell from your letter that you, too, are seeking it, and you will find it. The information sometimes comes in slowly, but you're doing the very best that you can do. That's enough.....(Marie Deatherage-Newsom, The Bridge, Autumn, 1988, p. 5)

Parents' stories may also help professionals to understand another perspective on partnership and parental empowerment. Cari's mother writes:

There were times when there were too many professionals involved. There were an infant learning specialist, a vision specialist, an occupational therapist, a physical therapist, a speech therapist, a physician, an ophthalmologist, and a child development specialist, all evaluating and treating her simultaneously.

Imagine a young, newlywed woman with eight mothers-in-law, and you get the picture. Each specialist had words of advice, sometimes conflicting. At times, I felt this child was not my own, but belonged to the professionals. I felt robbed of "normal" motherhood and even the right to make my own decisions. (Leff and Walizer, p. 158).

Stories from parents graphically illustrate how seemingly "small" behaviors—gently touching and interacting with babies as we go about therapeutic activities; sitting down on the floor with toddlers as we speak with parents; praising parents for their hard work; sharing our skills; shortening a lesson or therapy session in order to listen to a parent's pressing worries or concerns—deeply shape our healing roles.

Our home trainer let us know right away that Keough's handicap is secondary to her being, and that she likes Keough. She knows when it's time to dump the day's program and talk over coffee. She knows when one more medical referral or new program will be too much for us. She knows what she is doing and how to explain it to us...

The first thing Jan did when she initially came to our home was get down on the floor and play with our daughter. It made me feel good. Most of our friends, though very supportive of our daughter, treated her somewhat gingerly when it came to physical contact since she still had a feeding tube inserted in her stomach, but Jan launched right in.

She has told me since that this was a calculated move and something she tries to do each time she begins working with a new family. It tells them she likes their child, it puts her physically at a lower level than the parents, and it demonstrates that she's an informal, non-authoritarian person. It's very effective. More professionals ought to try it. (Duffy, 1984).

Stories from professionals

"Stories" from colleagues offer professionals the opportunity "to step back" and reflect upon their work. Stories validate our own experiences with children and parents, and allow us to identify painful or disturbing feelings in a non-threatening "emotional space" in which self-disclosure and introspection are valued. Stories encourage us to describe in vivid first-person language our reactions to difficult clinical situations *and* to experiment with solutions. Stories are a generous gift we give to one another as we strive to accept our human limitations, to develop tolerance for uncertainty, and to reach out to children and parents in crisis.

We enter professions serving very young children and families with the hope and expectation that children under our care will improve. Our daily work, at times routine and repetitive, is based on the goals of helping babies and toddlers to achieve their highest potential, to develop skills which will enable them to explore their world with pleasure. We base our definition of progress on the developmental needs and capacities of individual babies. With infants and toddlers developmentally "at risk," we applaud slow change and derive professional gratification from the gradual steps forward that will make a major positive cumulative impact on their lives.

Unfortunately, given the realities of our work, there will be babies whose impairments preclude happy endings. Instead of celebrating with parents as their babies learn and grow at their own pace, we are called to stand by parents as dreams crumble. We will meet parents who must deal with dashed hopes as the joy of "surviving" the NICU gives way to caring for a severely disabled baby with multiple and chronic medical and developmental needs. In addition, the early intervention staff must help such parents at a time of diminishing services and shrinking concrete resources.

These are trying, intense experiences for staff members striving to do their best. Struggling professionals may underestimate, even devalue, their own roles within the lives of parents seeking comfort and relief. A warm, seasoned specialist shares her feelings:

Jimmy could be considered a miracle of modern medicine. Blind, with cerebral palsy and profound mental retardation, he has endured multiple procedures and multiple hospitalizations. He requires frequent suctioning and gastrostomy feedings. Last week Jimmy's mother, Mrs. Smith, came to see me. She was softly crying as she spoke. "I can't do it anymore. I need a rest. I can't do it." The unrelenting pressure of caring for a child with multiple handicaps for days, months, and now years had taken its terrible, grinding toll.

***Finally**, after repeatedly calling and/or writing to several agencies, I was able to get 10 days of respite care. Ten days of respite. A drop in the bucket for this mother who has devoted her life to Jimmy's care. My frustration was overwhelming. I only wish I could do more for her. The resources just aren't out there.*

Desperate social and legal issues may invade our work. Bureaucratic rules and regulations may collide with one's own moral and ethical code. An experienced, committed infant specialist speaks of such a crisis:

I recall one of my most difficult experiences working with babies and families. I still have nightmares about this family. The mother was HIV-positive, and the baby was severely affected with AIDS, cancer, and multiple infections. The father refused—and I mean re-

fused—to be tested for the virus. The baby's mother knew that this man was having sexual intercourse with another woman. What was staff's responsibility? Legally, we could **not** *inform the other woman. Confidentiality ruled, and our licenses were at stake. But morally? This situation from so many years ago haunts me to this day and probably never will leave me.*

Pressing social problems will bring us face to face with circumstances in which parents' own self-loathing and hopelessness have shattered their relationships with their babies and have resulted in life-threatening child abuse or neglect. Recognizing the impact of her confrontation with the serious social ill of child abuse, a professional describes the effect on her own emotional well-being:

My most difficult feelings—the ones that have walked out with me after a day's work—involve the babies, toddlers, and preschoolers whose disabilities are tied to abuse or neglect. The kids exposed to alcohol or drugs in utero. The neglected infants. The kids beaten. My feelings alternate between intense anger and sadness. There is no comfort zone.

The more I am reminded by my colleagues about the mother's own background, —the more I know about the demons with which she has struggled — the less judgmental I become. So many of these abusive parents are among the walking maimed and wounded themselves. They have never known love. But my frustration never seems to subside. I just hope I can in some small way help to break the vicious cycle.

Openly discussing these tremendously difficult if insoluble problems rather than sweeping them under our "emotional rugs" prevents such experiences from sapping our energies and deeply depressing morale. Peer support is crucial; thus, group experiences involving the use of personal narratives may be uniquely valuable in educating for the healing partnership.

The use of stories in group experiences

Stories from parents and professionals may be used particularly effectively in a group setting to enhance empathy and introspection. Group experiences offer the safety of numbers; anonymity allows a degree of detachment and lessens defensiveness. In addition, the synthesis of many bright minds applying many skills and personal qualities to problems that all may encounter, creates a synergistic effect, producing insights and unanticipated growth. How should such group educational opportunities be designed?

Group educational opportunities, typically workshops or in-service training seminars, must take seriously the obligation of honoring principles of adult learning and effective practice:

1. **Participation should be voluntary.** Adults make decisions to learn in response to felt needs; when professionals sense inner discomfort with facets of their work lives, they welcome opportunities to develop skill and understanding, lending strength to the notion that "If you build it, they will come."

2. **The process focuses on applicable skills.** The many roles and responsibilities of professional life make **useful** learning goals imperative. Stephen Brookfield (1986) states, "As a rule,...[adults] like their learning activities to be problem-centered and to be meaningful to their life situation, and they want the learning outcomes to have some immediacy of application." (p. 31)

3. **Learning is cooperative and collaborative.** Learners take on different roles of leadership and participation. Adult learners create a synergistic effect, producing outcomes which are far more than the sum of the parts.

4. The process encourages continual **exploration and analysis of activities.** New ideas, new viewpoints are taken back and used to reexamine or reinterpret events and materials. This "praxis" is central to the education of adults.

5. The process promotes critical **thinking, allowing connections to be made between personal experiences and the workshop content.** As Brookfield points out: "While (facilitators) present their own ideas to learners as part of the teaching-learning transaction, they invite criticism and analytical scrutiny of these ideas by participants, and they are open to revising them as a result of this dialogue with learners." (p. 23)

6. **The activities are experiential.** In contrast to a lecture format which promotes detachment, useful approaches to continuing professional education are participatory and interactive, fostering involvement.

7. The program must respect the diversity of adults, with their unique physical, social, psychological, and professional levels of **development.** The process should be accessible to all, from referring and consulting physicians to assistant teachers doing the hands-on work with children.

As we have tried to incorporate these principles in workshops that use parental and professional narratives, we have learned that first-person stories elicit powerful language andemotion. Participants' feelings can be channeled constructively by "freezing the frame" at some point in a narrative and forming small groups in which participants try to imagine the thoughts, feelings, and expectations of the parents, the child, and the professional or paraprofessional

staff, (and whoever else might be a part of the story.) Participants may want to "speak for" the role which most closely resembles their own professional/personal identity, but they may also be encouraged to try to step into someone else's shoes, allowing new insights and interpretations of the story under discussion.

This approach requires no audiovisual aids. Facilitators can record on flip charts participants' comments concerning the valid yet conflicting needs of each person in a story, the pressures affecting their interactions, and their charged emotional states. If volunteers read the statements out loud, they are likely to do so with passion. Facilitators may need to encourage expression of possibly "controversial" views. Facilitators should be prepared for responses that they have not anticipated – in every group, we find our own viewpoints enlarged by the perspectives of participants.

Encouraged to consider likely results of a scenario, the participants gain insight into the more serious long-range impact of troubled parent/professional interactions. Group members can suggest alternate responses which might defuse and redirect a difficult situation and its immediate and long-range results. They may think of ways that a painful scene in a story might have been prevented, had planning, personnel, practice, or even facility design been otherwise. This opportunity for reflection and "action planning" empowers the participants and offersimpetus for "handling things better" in their own work.

Stories from professionals may explore barriers to our work–physical, social, emotional, and cultural–and open discussion and clarification of "limits:" What can we offer families? What is beyond our human capacities? If we learn to value what we <u>can</u> in reality accomplish in terms of reaching out to parents and standing by parents, we may allay the frustrations inherent in our work. Self-reflection and support counter the tension and raw anxiety that result in depressed morale and dissatisfaction with our work. We are thus enabled to grow, learn, and value our roles in the lives of children and their families.

In addition, first-person parental narratives offer professionals tools for helping parents to support and nurture themselves. In parent support groups, these stories may be used to "break the ice," alleviating initial stress and awkwardness and becoming catalysts for sharing and exploring feelings. Parents hear a healing message: others have survived the grief and pain; one is not alone. A professional shares:

Before we began using stories from parents of children with disabilities in our parents' group, the silence was deafening. The parents in our program felt isolated and alone. They feared disclosing their feelings–feared they were alone with their anger, terror, and sadness. The "stories" were our starting-off point. The group began to work for the parents when we introduced the stories. Parents began to share, to help each other, to sense safety in the group, to utilize the group as we had hoped they would.

In conclusion

Education for the helping professions which strives to foster empathy with children and parents in need requires commitment and time. Group experiences in which we explore together the poignant and moving stories of parents and professionals offer opportunities for renewing ourselves, replenishing our energies with the support of our colleagues and with the support of parents' hard-won wisdom. As we nurture those qualities of self-reflection and introspection which guide us toward an understanding of ourselves and of our helping roles, we find ourselves moving toward parents and children–learning, as we practice our challenging work.

A talented occupational therapist describes the deep source of professional gratification her work with parents affords:

...I'll extend my hand gingerly, yet not tentatively. I'll roll down my ladder, the rope one that swings unpredictably when you step on to it. Together we'll negotiate the future.

For many of our kids, there is very little concrete service we can provide. But I get parents down on the mat, or I get up on a chair and talk with them. I listen to their stories in an attempt to find the unifying theme and then work with that. I try desperately to balance professional knowledge with reality – to preserve the family unit and bond whenever possible.

I believe strongly that emotional well-being and security are as crucial to successful adaptation in society as any other aspect of function.

(Occupational therapy believes in human beings') inherent drive to master, and it is through this striving that wellness occurs. If I can provide the appropriate emotional and physical context for this to occur – for parents as well as for children – I have been successful.

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Of Elephants, Ethics, and Relationships: Tools for Transformation in the Training of Early Intervention Service Providers

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"No teaching is neutral; it is professional and personal, intellectually challenging and emotionally satisfying, an individual undertaking and a communal action."

– Mizell, Benett, Bowney, and Morin, *Different Ways of Teaching*, p. 41

We believe that students will learn best how to be responsive, empathic early intervention service providers through opportunities to examine their personal values, family history, and styles of interaction and communication in relationship to the families and infants they will be called upon to serve. As teachers, we create assignments (would "learning activities" be better?) that form a bridge between theory and practice, between the "self" and the "community," and between the student's developing personal resources and the demand for these resources that the student will face in the future, often under considerable pressure.

Our assignments to students include: 1) writing about their "personal manifesto" of principles in service delivery; 2) keeping a journal of their personal and professional reactions to infants and families in the course of a field practicum; and 3) writing about experiences on interdisciplinary team. Advanced students are offered a course in ethics, related specifically to biobehavioral/medical/early intervention issues.

Our approach to teaching was both tested and affirmed this past year. We share our individual experiences with you in the spirit of self-examination as teachers, and as part of a larger effort to prepare a new generation of family-centered advocates and providers in early intervention.

From Carole Brown:

The challenge came in the form of an "elephant experience."

When I first joined the George Washington University faculty, a senior colleague handed me a 7-page document she called "the elephant assignment." The name derived from an essay by a gentleman named David Aspy, who used the term "elephant experience" to refer to crises that we are unprepared to accommodate into our life processes. Aspy uses the image of having an elephant in the living room – something too large to assimilate into one's life alone. According to Aspy, when we find ourselves faced with something that has grown too large for the space that it formerly fit into quite comfortably, we must take steps (such as active seeking of social support) to cope with the overwhelming experience. If we can use an elephant experience constructively, to grow and ultimately integrate the personal meaning of that experience, we can be transformed.

Early intervention practitioners will inevitably encounter families in overwhelming circumstances. They themselves will feel overwhelmed in their work, and will need skills and insight to deal with that experience. So I use the "elephant assignment" is to help students identify their own transforming experiences. I ask them to read the Aspy essay and then to:

1. Identify your personal and professional "elephants" and describe how you handle them; and
2. Predict how your awareness of your elephants and the nature of your interpersonal style (e.g., communication, trust, etc.) will be beneficial to your paticipation on an interdisciplinary team.

Over the years, students have used the elephant assignment exceptionally well. However, a challenge came this spring, when a very talented student turned in a response that didn't reflect the assignment. The experience she described wasn't an "elephant." We talked about the issue several times, but she seemed not to understand my intent. As this student was from a culture in the Far East, I began to wonder if the assignment was culturally irrelevant for her. I paused, I pondered, and I began to consider offering the student and alternative assignment.

During this time, I came across an article in the *Chronicle of Higher Education* entitled "The Ethics of Requiring Students To Write about Their Personal Lives" (Swartzlander, et. al., 1993). The authors question the ethics of requiring students to engage in a process of self-revelation and then assigning a grade to the product of that process. How was I to grade my student? Clearly, she had missed the purpose of the assignment. That could be documented. But for me, her professor, to insist that she complete this assignment seemed invasive. Swartzlander and colleagues caution that requiring students to write about their personal lives might force a level of self-disclosure that could be dangerous to that student, or create an atmosphere of shame. Nothing in my student's behavior had suggested that she experienced danger in the assignment, but the article had made me realize that students might not always be able to protect themselves.

I began to wonder if I were simply wrong about the importance of the elephant assignment.

Shortly thereafter, I shared with the student some of my reservations about asking her to re-do the elephant paper. She then remembered an overwhelming experience that she had encountered in her previous nursing career as an adult patient was dying. Her eyes began to well up with tears. I worried that my probing had gone too far. I gave her a choice, to write about that experience or not. She opted to do it, writing about the nursing care of a comatose Korean man in his early twenties.

Much as I would like to avoid thinking of this "elephant experience," haunting memories take me back to it from time to time...

The elephant experience occurred when I returned from my lunch break. Upon entering Mr. L's room, I made my usual observations. The rhythmic long and short sounds of the respirator indicated that it was functioning perfectly in forcing air into Mr. L's lungs... (more detail on the routine of checking physical indicators)...Then I saw Mrs. L, his young wife, sitting near the floor, facing his bed. She was holding his fingers and resting her forehead on them. It seemed like she was praying or whispering to him. A voice near the foot of the bed brought me back to the present. That nasty voice commanded, "Mrs. L — no sitting on the pump."

I felt a dent in my heart made by the insensitivity of my colleague. I just stood there watching Mrs. L being sent away. I suddenly felt anger — anger at my colleague for her insensitivity and for stepping over my responsibility by telling Mrs. L where not to sit and to leave the room. The anger was also at myself for not intervening, and at the whole situation in which I allowed emotion to have control over common sense. I could have also offered a chair and could have come back to talk with her after the report. Instead, I did none of these!....

I had much trouble handling this experience. I found myself emotionally involved in the situation before I realized it. Things happened and ended very quickly. I did not ave a chance to organize my feelings and was therefore unable to deal with the situation justly and realistically...

This experience changed my view of my critical care nursing completely. My enthusiasm for high technology and for working against death became unappealing to me. I began to see more importance in the preservation of the living, and in support of the family members to help them cope with and understand dying. My energy since then has been spent more on hope and the future.

Shortly after this elephant experience, I transferred out of SICU to work on a kidney transplant unit. I enjoyed caring for persons with kidney failure and working with their families. We enjoyed watching every drop of urine produced by the new kidney. We celebrated, learned, hoped, and tried to make the dream come true.

This student's current study in early intervention is part of a continuing transformation. Reconnecting with her earlier overwhelming experience was very positive for her. As her teacher, experiencing a bit of my own elephant experience with this student, I was lucky. This assignment worked for her. Her ultimate success with it affirmed my understanding of the human condition and the growth process that often accompanies pain or loss.

I have regained my faith in the resiliency of my students. But I have also learned that the elephant assignment may not always work for everyone. I must respect my students' boundaries just as I expect them to learn to respect boundaries in their future interactions with families. I have learned to be vigilant, in order to ensure that the risks in self-awareness I ask students to take are reasonable, and that I am available to help them cope with their experiences.

From Barbara Hanft

The internal observing self is an important tool for members of any helping profession. Fonagy et al. (1991) define the "self" as the immediate experience of life; the "reflective self" is the internal observer of mental life which reflects upon conscious and unconscious mental experiences. Developing the ability to reflect on one's own thinking is a process which begins in childhood and continues throughout life. The development of self-reflective abilities in the child is similar to the later development of self-reflection by the professional-in-training (Towell & Rustin, 1991). Reflective skills can be used in preparing students to use self-observation as a professional tool, to distance and review the intense experience of hands-on interaction.

Reflection in the course of supervision and mentorship helps the trainee come to terms with what it means to go beyond doing what "comes naturally" to help babies and parents — to become a professional who works with infant, toddlers, and their families. (Fenichel, 1992, p. 13).

Until students participate in a practicum or other experiential learning situation, they will not have the opportunity to reflect on their own interactions. They will be dependent on learning vicariously, through their teacher's experience. A practicum goes beyond the traditional student/teacher relationship, by providing an opportunity for students to integrate past experience with emerging skills and knowledge. Most importantly a practicum lets students observe and participate in the relationships so essential to effective early intervention.

In a practicum, students must develop rapport with parents and other family members who are coping with many unknowns in a child's life. While written case histories can be discussed and debated in a classroom miles away from the reality of the principal characters' lives, interactions with family members in a practicum require the student to enter into a family's life story and become part of the dialogue. Students will hear family members' demands for immediate information that, they hope, will change their children's atypical growth and development. Students will watch a child struggle to raise his head or bring his thumb to his mouth, see the anguish on his father's face, and learn to respond in a caring and helpful manner -- a process quite different from reading a case study and thinking about how one might react to such a father.

Four students participated in a recent infant practicum I taught for the graduate education program in early intervention at George Washington University. The practicum includes a weekly seminar for students and an eight-week "play group" for parents and other family members of infants born prematurely. Each student was paired with a particular family for the duration of the practicum so that she would have an opportunity to establish a relationship with parents and observe an infant's behavior from week to week.

The first meeting of students and parents was structured as a get-acquainted session, using a simple needs assessment to guide the student/parent discussions. Part of each play group was devoted to a discussion time for parents while the students cared for the infants in an adjoining room. After all play group sessions, the students and I spent time reflecting on what they had observed about the infants' skills and behavior and what they had heard family members talk about and express interest in learning.

Students were assigned to keep a journal describing their reactions and feelings during the practicum. This assignment makes the student/teacher relationship more powerful, since it helps me guide the development of the student's reflective self. Reviewing the journal allows student and teacher to draw parallels between the student's observations of a child's development and the progression in her own thinking of herself as an early intervention professional. (ok?)

In the excerpts from journal entries which follow, practicum student K writes about A, an eight-month-old boy born at 24-weeks gestational age. K works as a child advocate in a foster care system in a large metropolitan area and is just beginning her training in early intervention.

Journal entry: Week one

In her first entry, as well as in seminar discussions, K acknowledges apprehension about whether she will "perform" appropriately and know what to say and do in unfamiliar territory.

Apprehensive is the word that best described my feelings tonight in class, and especially in the practicum setting. As I sat through the seminar, I could feel a tingling sensation in the pit of my stomach. I knew these feelings were not hunger pains, but were nerve pains. Here I was, about to embark on a new, unfamiliar territory of interacting with infants and their families. One might expect that I would feel comfortable because of my varied professional experiences. But one's past experience doesn't necessarily prepare one to navigate new waters.

Like the other practicum students, K does not have children of her own and was very interested in observing A's behavior. I spent time with K as she made her observations regarding A's development, pointing out, for example, how A's high muscle tone influenced his movement patterns, which in turn prevented him from sucking his thumb or holding himself up. These observations were discussed in light of conversations with A's father about his own observations of his son -- for example, what was happening at the babysitter's, recommendations from the therapists, what made A happy, and how best to calm him.

Journal entry: Week two

Since K was just beginning her professional preparation in early intervention, I did not expect her to make specific recommendations for individual infants. Rather, her task was to understand family issues and listen to parents so that she could understand their viewpoints, needs, and expectations of professionals.

It was interesting to hear the parents express their perceptions of their infants' miraculous birth and survival. As I moved around the mats, I heard comments such as, "My baby is a miracle," "My baby is a baby of promise," and "My baby is a survivor." I actually overheard one father asking another father, did he find himself at times staring at this baby, and the father responded with a resounding, "Yes." These parents seemed to have been expressing their gratitude for the birth of their babies, and their infants had survived the ordeal of their premature birth... What tremendous faith these parents have had to maintain to endure their infants' initial life-threatening experiences, the ICN experiences, the self-doubts, and the painful moments.

Journal entry: Week four

After the fourth session, I scheduled a special mid-term supervisory session with K to discuss her reactions and observations to the practicum experience. Much of the discussion involved K's future role in early intervention as related to her current job of working with teenage mothers. K told me how baffled she had felt initially as she listened to my observations of A's motor development and my explanation of the interrelationship of motor, cognitive, and social/emotional development during the neonatal period. She shared her surprise at realizing she had mastered new developmental information when she found herself looking at friends' children and pointing out why they did certain things, or correctly approximating an infant's age by observing his skill level.

K's comments caused me to reflect on how I was sharing my expertise with the students. I made an effort to help K see the developmental process she was undergoing in integrating new skills and knowledge.

What a difference two weeks have made in the developmental progress of A... The loosening up of these muscles were allowing him to perform fine motor skills such as bringing his arms together and bringing his hands to his mouth. It had appeared that a miracle had occurred in A's life, but in reality, he went through a rapid "growth spurt"...

What a difference two weeks have made in the developmental progress of myself as an infant interventionist educator. It provided invaluable time for me to read the assigned materials, to organize my thoughts, and to digest the written word. During the initial sessions, I was feeling lost in a web of strange terminology and developmental concepts. Now I am an active participant that has become alive through the power of mental comprehension.

In this practicum session, I discovered a young infant verging on the road to progress, and a professional on that same road.

Journal entry: Week eight

K's final assignment was to make a home visit to A (with his family's permission) to "practice" conducting an initial interview. Before making this assignment, I had devoted a class seminar to a role play, in which I took the role of a professional in an initial meeting between myself and the mother of a child with a severe physical disability. Students were encouraged to "stop the action" at any point and question the mother or me about the meaning of a particular comment or why we each reacted the way we did.

The home visit assignment provided the class with a wonderful opportunity to reflect on the advantages and disadvantages of working with family members in their own homes. Of course, each student had a very different experience; this diversity provided further material for reflection in the seminar. For K, A and his family were now "familiar territory"; meeting them at home was unfamiliar. I asked K to audiotape her interview so that she could play it back with me and reflect on any points raised by herself or A's father. (K and the other students met individually with me for this feedback, and then shared observations in the final seminar.)

As I approached the final practicum session, there were several words that described my feelings – confident, fulfilled, opportunity, compassionate, and understanding. However, the word "comfortable" best describes my emotions now. At the initial session, I was very apprehensive about my abilities as an infant interventionist educator. What a relief that fearful feeling has left my mind and the pit of my stomach!

In this practicum, I have learned invaluable life lessons, new material, and most importantly about myself.

Within the confines of the traditional classroom environment, it is difficult to give students opportunities to develop their skills in self-reflection about their own interactions with family members and colleagues. Even when the class is structured as a small seminar with discussion, interaction typically takes place at an intellectual, not personal, level. Students react to assigned readings, to one another, and to my descriptions of my experiences in early intervention settings – not their own. A supervised practicum provides the opportunity to help students reflect on their interactions with children and families – and to chart a course appropriate for their own professional development.

From Barbara Browne:

Ethics involves our ability to reflect on and critique our own morality, our laws, and our politics (John Fletcher, lecture, 1993). Ethical dilemmas and the issues surrounding them – nowhere more difficult than in work with infants and children with disabilities and their families – challenge us to reflect on and examine our current beliefs. At George Washington University, a week-long summer course called the Ethics Institute provides early intervention students with the opportunity for self-reflection, introspection and examination of their beliefs. The Institute examines medical, legal, ethical and psychosocial issues related to technological innovation in the care of infants and young children with special health care needs or disabilities. The Ethics Institute includes presentations from leaders in the field who discuss current and emerging trends; presentations by families of their experiences; group discussions; and small group case study discussions.

This course was originally organized and led by Edward Feinberg, Ph.D. As University Faculty Sponsor for the course, I had the unique opportunity to be an inactive participant-observer of his expert, creative leadership.

Ethics Institute students are encouraged to maintain personal journals as a vehicle for reflecting on the challenging issues presented in each class session. Writing in a journal can be a very useful way for students to sort out conflicting information beliefs. However, the difficulty of confronting ethical dilemmas may make journal writing quite difficult. We believe it is important to identify students' individual needs and respect their choices about participation in journal writing.

The journal entries below illustrate one student's initial ambivalence about and subsequent enthusiasm for the journal-writing experience. This young master's level student has worked in a hospital-based early intervention setting.

When I first approached the journal, I felt hassled. After all, the last thing I wanted to do following an intense day of medical, ethical debates was to go home and to ponder the material some more. Yet as I was able to sort my thoughts out on paper, I found myself experiencing

a sense of relief and peace beyond imagination.

As the course progressed, the evolution in her thinking became evident as she responded:

I first entered the course feeling rather secure with my personal values and positions in regard to the medical and ethical issues faced by those professionals working with medically vulnerable children and families. Yet as the course progressed and as I attained more information and heard more personal experiences, I found myself becoming more and more confused as to my own beliefs and feelings.

At the student became further immersed in the issues, she began to experience conflict as she reflected:

My journal writings reflect confusion, for my entries generally consist of questions followed by more questions, most of which are unanswered, and all of which conflict with one another.

The following excerpt highlights the power of the journal-writing experience, as well as the teacher's need to respect the individuality of each student and to provide a non-judgmental framework;

When I was able to go back and reflect on the thoughts contained in my journal writing, I came to a realization that has and will affect both my personal and professional life forever. Through such personal expression, I was able to realize and actually accept that there are times in our lives when confusion is a natural state of mind, and in such a situation, no simple and easy answers to questions exist.

Ultimately, the journal became the student's mechanism to transform her beliefs and blend old and new ideas into a partial resolution of conflict.

This concept (What concept is meant here?) is not new to me. However, it was only through allowing myself to reflect on the concrete words and phrases on paper that I was able to appreciate such concepts and, in effect, grow through such a realization.

The Ethics Institute course format and the accompanying journal reflections allowed this student to take a journey similar to that of many families who struggle to deal with new information and assimilate it into their lives. During the course, I noticed that the process for training our students in the Ethics Institute was parallel to the process that we recommend as best practice when students work with families. We encourage our students to provide families with knowledge and resources so they can make informed decisions about their child; to allow families to develop their own agendas; to validate what is important to them by identifying their interests and needs; to respect the individuality of each family; and to be nonjudgmental in their interactions with families.

The opportunity to examine and reflect on tough professional issues through an individual and group process allows students to re-evaluate and transform the concepts and ideas they brought to the course, and to examine challenging issues in an open, non-judgmental format. The Ethics Institute respects each individual as she faces every day the challenging realities of her life and work.

Conclusion

What I was beginning to realize was that teaching is most of all a special kind of relationship, a caring stance in the moving context of our students' lives. (Daloz, 1986, p. 14.)

Our relationship to our students forms the basis of our ability to facilitate transformation in the learning milieu. The illustrations we have drawn from our work serve to underscore the power of that relationships. Where we stand in relation to our students involves ethical decisions. Power is too easily abused without careful attention to ethical issues in teaching. Because we care about our students, we are never truly neutral in our relationship to them, no should we be.

We, like our students, are on a journey. We experience the overwhelming elephants overwhelming experiences with them, and we experience breakthroughs. We may become confused, as they do, in the process of teaching; we may have to realign our beliefs, just as they do. And in our relationships with students we try to be as nonjudgmental, objective, and respectful of differences as we expect our students to be with the families of infants and toddlers with special needs.

Education is something we neither "give" nor "do" to our students. Rather, it is a way we stand in relation to them. (Daloz, 1986, p. xv)

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ZERO TO THREE Notes

by Eleanor S. Szanton

ZERO TO THREE/NCCIP held a Board retreat in July. The purpose of the retreat was to review its past history and accomplishments, revisit its mission and set its course for the years ahead. The retreat provided an opportunity for real soul searching about the unique capabilities of **ZERO TO THREE**. How should we position ourselves to respond to changing societal and governmental circumstances? What functions or services can **ZERO TO THREE** perform or offer more effectively or with greater expertise than other organizations?

As a starting point, we created the following statement as a basis for our work:

While recognizing the many internal and external influences on a child's development, ZERO TO THREE focuses its attention on the quality of infants' and toddlers' major relationships and on children's day-to-day experiences within these relationships. From the first moments of life it is these relationships and these experiences that shape children's sense of self, the world, and their place in the human community.

The Board then turned its attention to action strategies that would have maximum impact on ultimately improving "the quality of children's day-to-day experiences within these relationships."

The Board identified three strategies that capitalize on the expertise of the **ZERO TO THREE** staff and Board and on the reputation it has built up through the years. First, it must **continue and expand its efforts to improve the quantity and quality of professional and paraprofessional training.** Second, it must **provide publications that showcase applied research and best practices** related to infants and young children. And third, it must **use its expertise to influence policymakers** so that young children become their first priority.

In the months and years ahead **ZERO TO THREE** will continue to articulate its mission, develop its strategies, and translate its mission into action.

One individual who has done as much as anyone to help **ZERO TO THREE** develop its original and ongoing mission is our founding Board member, **Albert J. Solnit, M.D.** Dr. Solnit was for many years the Director of the Yale Child Study Center. With a background in both child psychiatry and pediatrics, Dr. Solnit has been editor of *The Psychoanalytic Study of the Child*, one of the leading journals and groundbreakers in the development of "infant mental health" as a field. His works, *Beyond the Best Interests of the Child* and *Before the Best Interests of the Child*, written jointly with Anna Freud and with Yale Law School Dean Joseph Goldstein made a very great difference in the way in which courts and the child welfare system viewed parental and children's rights and needs. Dr. Solnit has recently retired from **ZERO TO THREE**'s Board of Directors as he became Commissioner of Mental Health for the State of Connecticut. However, he was unanimously voted to life membership. We salute him.

We are very pleased to welcome to membership on our Board three outstanding individuals, each of whom has worked in countless ways to enhance "infants' and toddlers' major relationships and on children's day-to-day experiences within these relationships."

Maria D. Chavez, Ed.D., is Director of Community Planning Department of Children, Youth and Families, State of New Mexico. Dr. Chavez has a long history of interest and experience in family resource programs. Both her academic work and her practical experience have been in this field, particularly as related to bilingual and bicultural issues. Some of her most interesting work has been in the area of parent empowerment and parents' central involvement in the planning and development of family-centered services.

Deborah A. Phillips, Ph.D., is Associate Professor of Psychology at the University of Virginia. She has taken a two-year leave of absence to serve as staff director of the Board on Children and Families of the National Academy of Sciences. She has a distinguished academic background in research and writing at the intersection of child development and social policy, particularly as it relates to child care. She has led or co-led several major research studies into the quality of child care, among them the National Child Care Staffing Study and the collaborative study on infant child care sponsored by the National Institute of Child Health and Human Development. Her academic publications are many; yet her concern for social policy has made her very well known in the world of "the trenches." She participated in **ZERO TO THREE**'s summit on infant day care in 1987.

Serena Wieder, Ph.D., is a clinical psychologist specializing in infant mental health, early intervention and prevention services, consulting and training at both the individual and the group level. She has been a pioneer in the field, doing work both related and unrelated to **ZERO TO THREE**. She was Principal Investigator and Clinical Director of the Clinical Infant Development Program, in collaboration with Dr. Stanley Greenspan. She was executive director of the Reginald Lourie Center for Infants and Young Children. She is the coordinator of **ZERO TO THREE**'s Diagnostic Classification Task Force Study. She co-edited the Clinical Infant Report, *Infants in Multi-risk Families*.

We welcome each of these individuals to our Board, as we work together to shape the nation's response, and our own, to the needs of infants, toddlers and their families.

Publications:

Handbook of Infant Mental Health (1993) - Charles H. Zeanah, Jr., editor (The Guilford Press, 72 Spring Street, New York, NY 10012) $55.00.

The 500-page *Handbook of Infant Mental Health* is designed to offer a broad interdisciplinary analysis of the developmental clinical, and social aspects of infant mental health. With 31 chapters written by scholars and clinicians from a variety of disciplines and perspectives, the work is grounded in a relational view of infancy and applies the findings of contemporary research in developmental psychology to the problems encountered in clinical practice.

Initial chapters critically evaluate different models of development and developmental psychopathology and the contexts of infant mental health, particularly the family. Subsequent chapters examine factors that may influence infant development, including adolescent motherhood, multiple family relationships, the consequences of poverty, and the effects of premature birth, parental mental illness, and maternal substance abuse.

Issues of assessment, evaluation, and diagnosis are covered in detail. Individual chapters address specific disorders of infancy, including autism and pervasive developmental disorders, mental retardation, posttraumatic stress disorder, failure to thrive, psychosomatic processes and physical illness, and disorders of attachment, communication, regulation, sleep, and feeding. The *Handbook* presents an array of intervention approaches, including practitioner-based models of psychotherapy and programmatic prevention and early intervention efforts. The final chapters on day care and child custody explore social policy questions related to infant mental health.

Contributors include Thomas Anders, Kathryn Barnard, Richard Bingham, Roseanne Clark, Susan Crockenberg, Martin Drell, Robert Emde, Theodore Gaensbauer, Cynthia Garcia Coll, Stanley Greenspan, Melvin Guyer, Nancy Hall, Robert Halpern, Della Hann, Robert Harmon, Laurence Hirshberg, Pauline Hopper, Thomas Horner, Alicia Lieberman, Karlen Lyons-Ruth, Susan McDonough, Samuel Meisels, Klaus Minde, Colleen Morisset, David Mrazek, Patricia Mrazek, Joy Osofsky, Jeree Pawl, Barry Prizant, Joanne Roberts, Arnold Sameroff, Jack Shonkoff, Clifford Siegel, Michael Thomasgard, Fred Volkmar, Bernice Weissbourd, Amy Wetherby, Serena Wieder, Charles Zeanah, Jr., Edward Zigler, and Barry Zuckerman, among others.

In the Beginning: Development from Conception to Age Two (Second Edition, 1992) - Judy F. Rosenblith (Sage Publications, Inc. 2455 Teller Road, Newbury Park, CA 91320) $48.00.

This 579-page text is designed for a broad range of students, including undergraduates with little exposure to psychology, beginning graduate students (with its orientation toward evaluation of empirical research), and students in a variety of disciplines. The author describes two major aims "not often seen in textbooks": 1) to embed the presentation of current data on and ideas about the functioning of infants in a historical context; and 2) to present the material in a way that will maximize learning about the **process** of studying infants as well as the **content** derived from that study (emphasis added). To do this, the text emphasizes discussion of research methods and issues; controversies in infancy studies; practical implications of infancy research; theoretical perspectives; and vocabulary.

The text is divided into four parts: 1) conception through birth; 2) early characteristics and development; 3) the fundamental processes (including cognitive development, early communicative and language behavior, and social development); and the social context, featuring a discussion of the influence of environment through deprivation and enrichment.

Working Together with Children & Families: Case Studies in Early Intervention (1993) - P.J. McWilliam and Donald B. Bailey, Jr., editors (Paul H. Brookes Publishing Co., P.O. Box 10624, Baltimore, MD 21285) $23.00.

Begun as part of the work of the Carolina Institute for Research on Infant Personnel Preparation (CIRIPP), this volume includes case studies that appeared in the CIRIPP publication, *The Families We Serve*, as well as case studies selected from responses to an open invitation to the field. Each case study includes discussion questions designed for use by instructors or independent readers. (For example: "Did Kathy handle the telephone call to Susan in an appropriate manner? What did she say or do to facilitate a productive exchange? Could she have done anything differently to improve the exchange?")

All of the 21 case studies in the book are based on actual experiences of professionals working in early intervention. Features of individuals and situations have been changed to preserve confidentiality, and in many of the cases editors have added dialogue or descriptions of professionals' thoughts and emotions.

P.J. McWilliam notes:

If there is an overriding theme in this book, it is the celebration of the individual. Current academic writings about early intervention reverberate with messages about the importance of individualizing services for children and families. In the written transmission of theory, research, and recommended practices, however, clear pictureof individuals are seldom offered. It is hoped that this book will (offer) clear pictures of children without labels, families with unique values, and professionals with feelings of their own...Most important, the stories provide specific examples of factors to consider in applying recommended practices on a case-by-case basis.

If any aspect of this book endures the test of time, it will be the concept of building relationships. Each of the case studies...tells a tale about the importance of relationships – between parents and their children, between parents and professionals, and between professionals and other professionals.

The Child's Path to Spoken Language (1993) - John L. Locke (Harvard University Press, 79 Garden Street, Cambridge, MA 02138) $39.95.

This volume is an effort to synthesize the latest research on early language acquisition, examining closely the process by which human babies progress gradually from babbling to shaping meaningful sentences. *The Child's Path to Spoken Language* covers neurological, perceptual, social and linguistic factors that shape the vocal, neural and cognitive capabilities humans require in order to successfully master language.

Locke first explores what accounts for infants' ability to detect and process environmental stimulation relevant to language; he next addresses the factors, including prenatal learning, influencing the neonate's orientation to the physical cues given when people speak. *Spoken Language* examines the social relationships that are the context within which linguistic communications develop; Locke draws on findings on nonhuman primates and songbirds as well as humans, and clinical populations that include tracheotomized infants and children with impaired vision or hearing, retardation, autism, and brain damage.

In tracing the growth and differentiation of the child's vocal and articulatory capacities, Locke explores how the newly formed syllabic potential might converge with affective vocalization to produce speech. The neural implications of interpersonal communication by way of face, voice and linguistic expression are outlined, followed by an examination of how children with emerging neural capabilities move along the path of cues and interactions that lead to mastery of spoken language. Locke also explores the neurobiology of linguistic variation–what accounts for the variability in language development from one child to the next?

Daycare, Revised Edition (1993), Alison Clarke-Stewart (Harvard University Press, 79 Garden Street, Cambridge, MA 02138) $22.95 cloth, $9.95 paper.

Alison Clarke-Stewart first published *Daycare* 10 years ago; in her preface to this edition, she notes the need for a revised work because "the problems of daycare are still with us, and the situation has become even worse....There must be a concerted effort to educate all Americans – those in positions of power as well as those with young children – about the importance of good daycare."

With the stated purpose of "helping working and would-be working mothers solve some of the problems of arranging for satisfactory daycare," Clarke-Stewart offers an overview of the social, political, and economic landscape of daycare in the ensuing years. *Daycare* includes chapters outlining the need for daycare, its history and effects on children, the state of daycare today, finding good care, daycare in other nations and the future. Chapter Six, "Places, Programs, Peers," examines three aspects of daycare that affect children's experiences and learning–the physical space and equipment, the educational program or curriculum, and the presence of other children. In Chapter Eight, "Infants and Individuals," Clarke-Stewart discusses variations in daycare effects for children of different ages, sexes and personalities.

Chapter Nine discusses federal requirements and offers quality guidelines drawn from research, an observation checklist for "scoring" a child care facility, and suggestions for ensuring continued quality. *Daycare* includes extensive annotations, a suggested reading list, and a detailed index.

Letter to the editor:

I have just finished reading the remembrances of Sally Provence (*Zero to Three*, June/July, 1993), and they warmed my heart. I met Dr. Provence while an intern at the Child Study Center and, like so many of her students and colleagues, was both impressed and touched by her clinical acumen, her sensitivity, and her respect for children. What particularly warmed my heart and inspired me in reading the remembrances was her steadfastness and hope.

Dr. Provence was a beacon for many. The remembering and sharing is so important, especially as children continue to be ignored, devalued, and assailed in so many places. Thank you for providing this opportunity to hear Sally Provence's voice once again, but this time through her students and colleagues.

Ana M. Sierra, Ph.D., Children & Family Resource Center, St. Charles, Illinois

Videotapes:

Discoveries of Infancy: Cognitive Development and Learning (1991). *Producer*: J. Ronald Lally, Far West Laboratory for Child and Family Studies, in collaboration with the California Department of Education. *Available from*: California Department of Education, Bureau of Publications, Sales Unit, P.O. Box 271, Sacramento, CA 95812-0271, (916) 445-1260. 32 min. $65.

In this videotape, infants and toddlers in the company of their care givers demonstrate the process of discovery and learning. Infants learn from what they see, hear, feel, taste and touch. They concentrate, solve problems and experiment. They order, classify and integrate information. Infants begin learning through simple sensory-motor experiences and move toward acquiring the power of reasoning.

Discoveries of Infancy: Cognitive Development and Learning explores the constant quest for knowledge of infants and toddlers. The video depicts infants and toddlers as they make the kinds of discoveries typical of the first three years of life: learning schemes, cause and effect, use of tools, object permanence, understanding space, and imitation. The video offers guidelines on how to support the learning of very young children.

This video is part of The Program for Infant Toddler Care Givers, produced by J. Ronald Lally at Far West Laboratory Center for Child and Family Studies and developed in collaboration with the California Department of Education. Designed for caregivers, trainers of caregivers, and parents, the Program includes videos on Social-Emotional Growth and Socialization (Module I); Group Care and Culture (Module II); Learning and Development (Module III); and Family and Providers (Module IV). All ten videos in the Program are available in English, Spanish, and Chinese and are accompanied by a video magazine. A curriculum guide is available for each module.

Infant Mental Health: A Psychotherapeutic Model of Intervention *Producer*: Michael Trout, Infant-Parent Institute, Champaign, Illinois. *Available from*: Child Health and Development Educational Media, 5632 Van Nuys Blvd., Suite 286, Van Nuys, CA 91401, (818) 994-0933. 95 min. $195.

Infant Mental Health: A Psychotherapeutic Model of Intervention includes three interrelated yet distinct video training segments. The initial 23 minute segment, "Opportunities for Intervention," describes some of the ways in which mothers, fathers, and babies reveal that they are "in trouble." Case examples illustrate the circumstances in which infant mental health clinicians offer thoughtful, respectful, principled help.

Part two of the tape, "Principles of Intervention," (49 minutes) examines the major philosophical, strategic, practical and clinical issues in infant-parent psychotherapy. Case examples are used to present the ideas of clinicians and the ways they work in various settings in the United States, Canada, Senegal and Switzerland.

"Issues in Clinical Infant Mental Health" (23 minutes), the final segment of the tape, identifies questions emerging in the field:

* Are we finding ways to truly engage fathers, grandparents, and others in the family matrix?

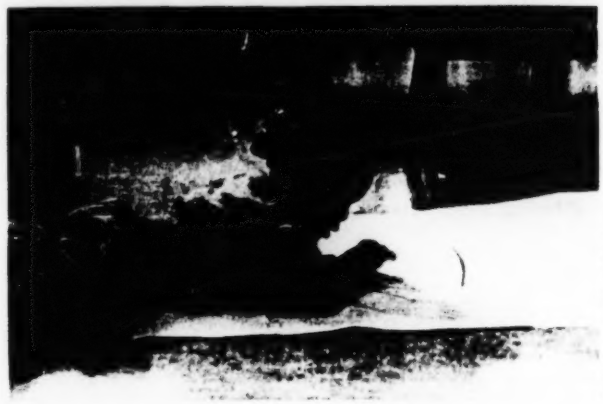
* How shall we understand differences (cultural, racial,religious, sexual, life style) and attend to differences in psychotherapeutic work?

* What is our experience to act in the world, extra clinically, when confronted by forces that harm babies and families?

Infant Mental Health: A Psychotherapeutic Model of Intervention is accompanied by a viewers' guide that includes a transcript of clinical issues and a reading list. The tape is the sixth unit of The Awakening and Growth of the Human: Studies in Infant Mental Health, a videotape series, for clinicians who work with infants and their families. The series was produced and narrated by Michael Trout at The Infant-Parent Institute.

First Years Together: Involving Parents In Infant Assessment. *Producer*: Project Enlightenment, Wake County Public Schools, Raleigh, North Carolina. *Available from*: Child Health and Development, 5632 Van Nuys Blvd., Suite 286, Van Nuys, CA 91401, (818) 994-0933. 19 min. $65.

This video is based on the experiences of parents and professionals who participated in First Years Together, an early intervention program for high risk infants and their families. The program developed a model assessment process which recognizes that parents come to an evaluation of their infant with concerns about the infant and about themselves and their ability to parent an infant who has had a worrisome start. The video demonstrates the significance of involving parents in infant assessment as an opportunity for intervention, support and education. In both formal and informal assessment



Subjects & Predicates

situations, the needs of parents can be addressed as well as the needs of the infant.

First Years Together: Involving Parents In Infant Assessment was designed for professionals in mental health and health-related fields and for families whose infants were born prematurely or with conditions requiring follow-up. In the video, parents and professionals describe the positive outcomes of an assessment approach that:1) identifies the infant's strengths and weaknesses; 2) acquaints parents with the infant's developing characteristics; and 3) acknowledges parents' efforts to support the development of their child. The video suggests that when informed parents participate in the assessment process, they have the opportunity to talk about how they see their child and identify their concerns and priorities. With full parent participation, the assessment of the infant is more accurate, a better understanding of the infant within the family emerges, and parents are more able to meet the needs of their child.

Interdisciplinary Teamwork: A Team in Name Only and Becoming An Effective Team (1991). *Producer*: Virginia Institute for Developmental Disabilities, Virginia Commonwealth University, Richmond, Virginia. *Available from*: Child Health and Development, 5632 Van Nuys Blvd., Suite 286, Van Nuys, CA 91401, (818) 994- 0933. 44 min. $65.

This two-part video (each segment is 22 minutes) emphasizes the effects of team process on recipients of team services - young children with disabilities and their families. Team processes include communication, trust, leadership, the structure of the team meeting, shared values, team problem solving, decision making, conflict resolution, feedback, and team satisfaction. A team's ability to provide effective, consistent and coordinated services is dependent on mastery of these processes. This tape is designed for the education and training of professionals to provide a common basis for discussion of the components of team process, the barriers to teamwork and the steps teams can take to improve their functioning.

Both segments of the video focus on the family of a young child with disabilities and provide the opportunity to see a team in action, at first not functioning effectively and then learning to do things right. In *A Team in Name Only*, members of the team express their personal perspectives regarding the team's problems and what is needed. In *Becoming an Effective Team*, the team members describe changes in team functioning and how the changes were achieved. In both segments the issues raised by team members are illustrated in team meetings.

Although the two video segments focus on a family of a young child with disabilities, the issues raised and the processes depicted are common to human services teams serving individuals across the life span. A guide for trainers and viewers accompanies the video.

ECO VIDEO II: Adult Communicative Styles with Pre-conversational Children, Infants Toddlers Pre-schoolers (1992). *Producer*: Stacey Davidson and James D. McDonald, The Nisonger Center, Ohio State University, Columbus, OH. *Available from*: Child Health and Development Educational Media, 5632 Van Nuys Blvd. Suite 286, Van Nuys, CA 914011, (818) 994-0933. 6 tape series $250.

The purpose of this video series is to train adults to communicate with children in ways that help children develop language and communication. ECO VIDEO II is based on the ECO Model of early intervention for children with delayed language. This model of intervention actively engages children and their social ecology, including relationships and play contexts, that provide natural support for communication and language learning. ECO identifies the kinds of activities and relationships that will lead to child communication/language development. ECO focuses on social interaction, with active parental/adult participation, as key to a child's language and communication development. ECO shows adults ways to interact with children that invite children to stay longer in interactions, thereby increasing children's opportunities to learn from adults.

The ECO model identifies adult interaction styles - BALANCE, MATCH, RESPONSIVENESS, NONDIRECTIVENESS and EMOTIONAL ATTACHMENT as critical in supporting young children's communication development. Each 20-minute tape in the ECO VIDEO II series examines one of these adult interaction styles. The tapes demonstrate interaction styles, contrast styles, review a system for evaluating each style, and present an adult-child interaction and the opportunity to evaluate the interaction styles. ECO VIDEO II, and the accompanying workbook and training manual, were produced at the Nisonger Center by Stacey Davidson and James McDonald to guide parents, students and professionals to become natural language learning partners with children.

Conference Call:

October, 1993

October 1-3: ***The Healthy Mothers,Healthy Babies Coalition*** will hold its 7th National Conference in Arlington, Virginia on the theme, "Cultural Diversity: Are We Serving the Changing Populations?" Plenary sessions will discuss managed care, community outreach workers, and data collection and analysis among communities of color. Contact Healthy Mothers, Healthy Babies Coalition, 409 12th Street, SW, Washington, DC 20024-2188, tel: (202) 863-2458.

October 22: ***The Illinois Association for Infant Mental Health,*** an affiliate of the World Association for Infant Mental Health, will hold its 10th annual conference, "Vulnerability and Resilience: Hope in Changing the Course of Development," in Wilmette, Illinois. The Irving B. Harris Keynote Speaker will be Carolyn Zahn-Waxler, with Fran Stott as discussant. Contact Mark Valentine, JPA Parent-Infant Center, 3655 N. Ashland, Chicago, IL 60613, tel: (312) 935-5985.

October 22-23: ***Teachers College, Columbia University*** will sponsor a conference in New York City "Caring and Competency: Infancy through Kindergarten." Speakers will include Annette Axtmann, Jeanne Brooks-Gunn, Rebecca Shahmoon Shanok, and Leslie Williams. Contact Annette Axtmann, Center for Infants and Parents, Teachers College, Columbia University, New York, NY 10027, tel: (212) 678-3013.

October 23: ***The C.M. Hincks Institute*** will sponsor a conference in Toronto, Ontario on "John Bowlby's Attachment Theory – Recent Findings: Implications and Applications." Speakers will include Mary Main, Karin Grossmann, Giovanni Liotti, Kenneth Adam, Dante Cicchetti, and Patricia Crittenden. Contact Edythe Nerlich, C.M. Hincks Institute, 114 Maitland Street, Toronto, ON M4Y 1E1, Canada, tel: (416) 972-1935 x3347; fax (416) 924-9808.

November, 1993

November 4-7: The ***Administration on Children, Youth and Families,*** in collaboration with the ***National Council of Jewish Women Center for the Child*** and the ***Society for Research in Child Development,*** will hold the 2nd National Head Start Research Conference, "Translating Research into Practice: Implications for Serving Families with Young Children," in Washington, D.C. Urie Bronfenbrenner and Marian Wright Edelman will be keynote speakers. Contact the NCJW Center for the Child, 53 West 23rd Street, New York, NY 10010, tel: (212) 645-4048; fax (212) 645-7466.

November 4-7: The ***National Perinatal Association*** will hold its annual clinical conference and exposition in Chicago, Illinois on the theme, "Perinatal Care: Bridging the Gap between Knowledge and Practice." Contact Contemporary Forums Conference Management, 11900 Silvergate Drive, Suite A, Dublin, CA 94568-2257, tel: (510) 828-7100 x3 or NPA, tel: (813) 971-1008.

November 6: ***Boston Institute for the Development of Infants and Parents, Inc.*** (BIDIP) will hold its 18th annual conference in Medford, Massachusetts on "Infant/parent Assessment and Evaluation: New Directions for the Nineties." Speakers will include Jack P. Shonkoff, Cynthia Garcia-Coll, and Barry M. Prizant. Contact BIDIP Conference, 26 Trapelo Road, Belmont, MA 02178, tel: (617) 484-6603.

November 10-15: The ***National Council on Family Relations*** will hold its 55th annual conference in Baltimore, Maryland, on the theme "Moral Discourse on Families." Plenary speakers will include Andrew Billingsley, Jean Bethke Elshtain, and Susan Moller Okin. Contact National Council on Family Relations, 3989 Central Avenue, NE, Suite 550, Minneapolis, MN 55421.

November 11-14: The ***National Association of Child Advocates*** will hold its 8th national conference in New Brunswick, New Jersey, on the theme, "Pathways to a Better Tomorrow: Child Advocacy Strategies i States and Communities." Speakers will include Peter Goldberg, Richard Murphy, Sara Rosenbaum, and Patricia A. White. Contact Tamara Jackson, National Association of Child Advocates, 1625 K Street, N.W., Suite 510, Washington, DC 20006.

November 30 - December 4: The ***National Center on Child Abuse and Neglect, ACYF, DHHS,*** along with national and local co-sponsors, will hold the 10th national conference on child abuse and neglect in Pittsburgh, Pennsylvania, with the theme "Building Bridges to the Future." Contact Research Assessment Management, Inc., 1300 Spring Street, Suite 210, Silver Spring, MD 20910, tel: (301) 589-8242, fax: (301) 589-8246.

December, 1993

December 2-5: ZERO TO THREE/*National Center for Clinical Infant Programs* will hold its Eighth Biennial National Training Institute in Washington, D.C. with the theme, "Joining Forces with Infants, Toddlers and Their Families." Plenary speakers include Barry Zuckerman, T. Berry Brazelton, Margot Kaplan-Sanoff, Robert Needlman, Carol Brayboy, Samuel Meisels, Asa G. Hilliard, III, Stanley Greenspan, Susan Rocco, J. Ronald Lally, Yolanda Ledon Torres, Pamela C. Phelps, Alicia F. Lieberman, Urie Bronfenbrenner, Gina Barclay-McLaughlin, and Ann Turnbull. Contact ZERO TO THREE -NTI, P.O. Box 7270, McLean, VA 22106-7270, tel: (703) 356-8301, FAX: (703) 790-7237.

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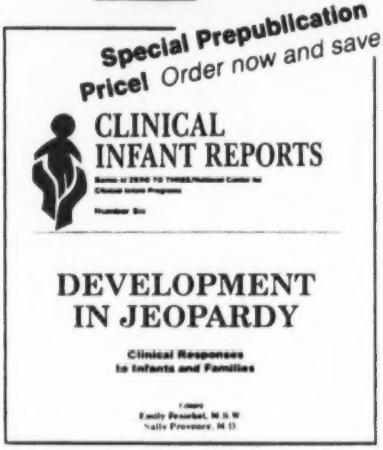

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DEVELOPMENT IN JEOPARDY

Clinical Responses to Infants and Families

Monograph 6 in the ZERO TO THREE/National Center for Clinical Infant Programs Series

Edited by Emily Fenichel, M.S.W. and Sally Provence, M.D.

"This is a most remarkable volume. From the fascinatingly informative Introduction by editors Fenichel and Provence to the last chapter, the volume contains useful clinical data on a wide variety of cases involving children in the first three years of life. Each chapter is about children and their families who are in jeopardy of one sort or another. The presenting condition of jeopardy is not as important as the reflections of the authors in their approaches to the family unit around issues of distress.

"The chapter authors, representing a variety of psychotherapeutic disciplines, have great expertise in attending to the problems of infants and young children, and in reflecting on their own problems in handling very difficult circumstances. **They make the field of infant psychotherapy come alive with poignant dialogue, astute observations, and keenly crafted interventions.**

"The volume is data-rich with clinical observation, and is full of wisdom concerning alternative modes of intervention. Clinical scientists will find much to please them in the construction of hypotheses about the origin and course of developmental jeopardy. **Years from now, clinicians and critics will be grateful that the editors dared to place this pioneering volume before them in 1993."**

—Lewis P. Lipsitt, Ph.D.

This volume, the sixth in the highly praised series of Clinical Infant Reports published by ZERO TO THREE/National Center for Clinical Infant Programs, meets a widely acknowledged need for detailed case studies which illustrate diagnostic and therapeutic issues and methods specific to work with children from birth to three and their families.

Each of the seven case reports in this book begins with a child, or children, in the first three years of life, whose healthy development is in jeopardy. Each report then describes in detail the clinical response of one or more professionals to the infant, and to his family. Contributors report on their work with infants and toddlers whose development may be compromised because of disability, because of risks in the caregiving environment, or because of troubled relationships within the family. They describe interventions offered in hospitals, homes, social service agencies, early intervention programs, mental health clinics, and courtrooms.

The detailed case reports in this volume allow the reader to see how elements of a clinical response interact. These reports reveal what manuals, protocols, guidelines, and even program evaluations and outcome measures cannot: how one baby, one family, and one set of would-be helpers, with all their combined strengths, skills, resources, vulnerabilities, and histories, worked together for the healthy growth of the child. The contributors to this volume have recorded with care the language, behavior, emotional style, appearance, and other telling details about the infants and families with whom they have worked. They describe the opportunities and limits of their own work settings, their insights and perplexities as they make decisions, and their emotional responses as the work continues.

CONTENTS: Introduction. CLINICAL RESPONSES TO INFANTS AND TODDLERS WITH DISABILITIES AND THEIR FAMILIES.
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Stitches in Time: Using Emotional Support, Developmental Guidance, and Infant-Parent Psychotherapy in a Brief Preventive Intervention, *Jeree H. Pawl.*
Infant-Family Psychotherapy: One Approach to the Treatment of Infant and Family Disturbances, *Chaya H. Roth and Margie Morrison.* Index.

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